Blue Cross and Blue Shield of Nebraska

Medicare Supplement Outline of Coverage

Benefit Plans: A, B, C, F, G, L and N

Rates Valid: April 1, 2025, through March 31, 2026
For Plans Effective: Jan. 1, 2026, through Dec. 31, 2026

9175-JAN (12-18-25)

Table of Contents

BENEFIT CHART OF MEDICARE SUPPLEMENT PLANS 3

MONTHLY PREMIUMS

AREA 1 (ZIP Codes 680-681) 4

AREA 2 (ZIP Codes 683-685) 8

AREA 3 (ZIP Codes 686-689) 12

AREA 4 (ZIP Codes 690-693) 16

IMPORTANT INFORMATION 20

PLAN DESCRIPTIONS

PLAN A 22

PLAN B 24

PLAN G 26

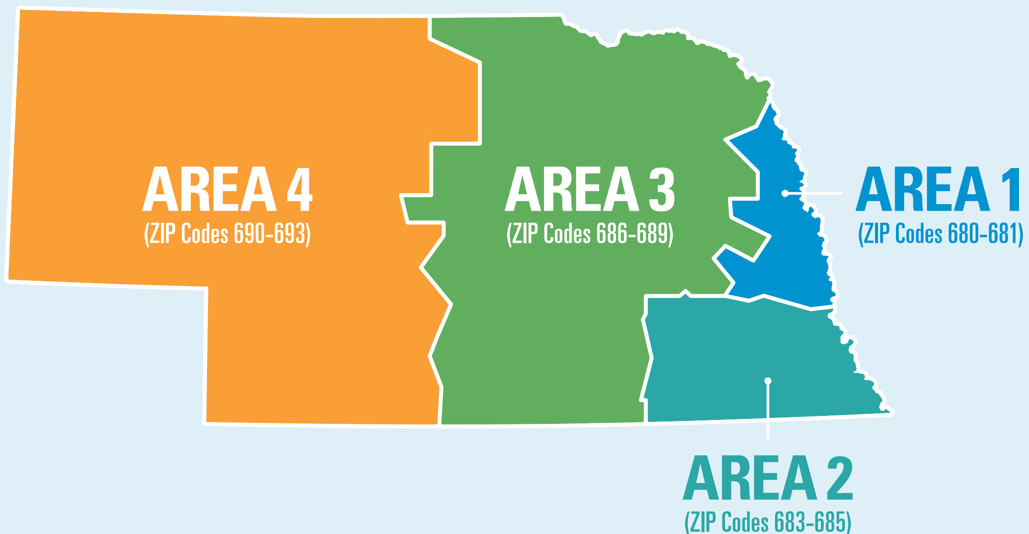
PLAN N 28

PLAN L 30

PLAN C 32

PLAN F 34

RATE ZONES | Based on ZIP Code



Benefit Chart of Medicare Supplement Plans

For Plans Effective: January 1, 2026, through December 31, 2026

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.

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

	Plan A	Plan B	Plan D	Plan G[1]	Plan K	Plan L	Plan M	Plan N	Plan C (Medicare first eligible before 2020 only)	Plan F[1] (Medicare first eligible before 2020 only)
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%	✔	✔[3] copays apply	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility care 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 2026[2]					$8,000[2]	$4,000[2]				

1 Plans F and G also have a high deductible option which require first paying a plan deductible of $2,950 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

2 Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

3 Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in inpatient admission.

Blue Cross and Blue Shield of Nebraska only offers Plans A, B, C, F, G, L and N.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 1 (ZIP Codes 680-681)

Age	Plan A**		Plan B		Plan G		Plan L		Plan N		Plan C		Plan F	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	309.65	269.25												
65	206.43	179.50	258.88	225.11	187.40	162.95	143.45	124.74	134.44	116.91	240.28	208.94	267.16	232.31
66	206.43	179.50	258.88	225.11	187.40	162.95	143.45	124.74	134.44	116.91	240.28	208.94	267.16	232.31
67	206.43	179.50	258.88	225.11	187.40	162.95	143.45	124.74	134.44	116.91	240.28	208.94	267.16	232.31
68	217.78	189.37	273.11	237.49	197.70	171.91	151.33	131.59	141.84	123.34	253.50	220.44	281.85	245.09
69	229.13	199.24	287.36	249.88	208.01	180.88	159.22	138.45	149.24	129.77	266.71	231.92	296.55	257.87
70	240.49	209.12	301.60	262.26	218.31	189.84	167.11	145.31	156.62	136.19	279.93	243.42	311.24	270.65
71	250.81	218.09	314.54	273.51	227.69	197.99	174.29	151.55	163.35	142.04	291.95	253.87	324.60	282.26
72	261.13	227.07	327.48	284.76	237.06	206.14	181.45	157.79	170.07	147.89	303.96	264.31	337.95	293.87
73	271.45	236.05	340.42	296.02	246.42	214.28	188.63	164.03	176.79	153.73	315.97	274.76	351.32	305.49
74	281.78	245.02	353.37	307.28	255.80	222.43	195.80	170.26	183.52	159.58	327.99	285.21	364.68	317.11
75	292.09	253.99	366.32	318.54	265.16	230.57	202.98	176.50	190.24	165.42	340.01	295.66	378.03	328.72
76	301.39	262.08	377.96	328.66	273.59	237.91	209.43	182.12	196.29	170.69	350.81	305.05	390.06	339.18
77	310.67	270.15	389.61	338.79	282.03	245.24	215.89	187.73	202.34	175.95	361.63	314.46	402.07	349.63
78	319.96	278.23	401.26	348.93	290.46	252.58	222.35	193.34	208.38	181.20	372.44	323.86	414.10	360.09
79	329.26	286.31	412.91	359.05	298.90	259.91	228.79	198.95	214.44	186.47	383.25	333.26	426.12	370.54
80	338.54	294.39	424.56	369.18	307.33	267.24	235.25	204.56	220.49	191.73	394.06	342.67	438.15	381.00
81	345.77	300.67	433.62	377.06	313.89	272.94	240.27	208.93	225.20	195.82	402.48	349.98	447.49	389.12
82	352.99	306.95	442.68	384.94	320.45	278.65	245.29	213.29	229.89	199.91	410.89	357.30	456.84	397.25
83	360.22	313.23	451.75	392.83	327.01	284.35	250.31	217.66	234.60	204.00	419.30	364.61	466.19	405.38
84	367.44	319.51	460.81	400.70	333.56	290.05	255.33	222.02	239.31	208.10	427.70	371.92	475.54	413.52
85	374.66	325.79	469.86	408.58	340.13	295.76	260.35	226.39	244.01	212.18	436.12	379.23	484.90	421.65
86	377.76	328.49	473.75	411.96	342.94	298.21	262.51	228.27	246.03	213.94	439.72	382.37	488.90	425.13
87	380.86	331.18	477.63	415.33	345.74	300.65	264.66	230.14	248.05	215.70	443.33	385.50	492.91	428.62
88	383.96	333.88	481.52	418.71	348.56	303.10	266.81	232.01	250.06	217.45	446.93	388.64	496.91	432.10
89	387.05	336.57	485.40	422.09	351.37	305.54	268.96	233.88	252.08	219.20	450.54	391.77	500.92	435.58
90+	390.15	339.26	489.28	425.46	354.18	307.98	271.11	235.75	254.09	220.95	454.14	394.91	504.93	439.07

Plan C and Plan F: Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025.
Premium payment may be made monthly.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 1 (ZIP Codes 680-681) – Household Discount Applied*

Age	Plan A**		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	263.21	228.85								
65	175.47	152.57	220.05	191.34	159.29	138.51	121.93	106.03	114.27	99.37
66	175.47	152.57	220.05	191.34	159.29	138.51	121.93	106.03	114.27	99.37
67	175.47	152.57	220.05	191.34	159.29	138.51	121.93	106.03	114.27	99.37
68	185.11	160.96	232.14	201.87	168.04	146.12	128.63	111.85	120.56	104.84
69	194.76	169.35	244.26	212.40	176.81	153.75	135.34	117.68	126.85	110.30
70	204.42	177.75	256.36	222.92	185.56	161.36	142.04	123.51	133.13	115.76
71	213.19	185.38	267.36	232.48	193.54	168.29	148.15	128.82	138.85	120.73
72	221.96	193.01	278.36	242.05	201.50	175.22	154.23	134.12	144.56	125.71
73	230.73	200.64	289.36	251.62	209.46	182.14	160.34	139.43	150.27	130.67
74	239.51	208.27	300.36	261.19	217.43	189.07	166.43	144.72	155.99	135.64
75	248.28	215.89	311.37	270.76	225.39	195.98	172.53	150.02	161.70	140.61
76	256.18	222.77	321.27	279.36	232.55	202.22	178.02	154.80	166.85	145.09
77	264.07	229.63	331.17	287.97	239.73	208.45	183.51	159.57	171.99	149.56
78	271.97	236.50	341.07	296.59	246.89	214.69	189.00	164.34	177.12	154.02
79	279.87	243.36	350.97	305.19	254.06	220.92	194.47	169.11	182.27	158.50
80	287.76	250.23	360.88	313.80	261.23	227.15	199.96	173.88	187.42	162.97
81	293.90	255.57	368.58	320.50	266.81	232.00	204.23	177.59	191.42	166.45
82	300.04	260.91	376.28	327.20	272.38	236.85	208.50	181.30	195.41	169.92
83	306.19	266.25	383.99	333.91	277.96	241.70	212.76	185.01	199.41	173.40
84	312.32	271.58	391.69	340.59	283.53	246.54	217.03	188.72	203.41	176.88
85	318.46	276.92	399.38	347.29	289.11	251.40	221.30	192.43	207.41	180.35
86	321.10	279.22	402.69	350.17	291.50	253.48	223.13	194.03	209.13	181.85
87	323.73	281.50	405.99	353.03	293.88	255.55	224.96	195.62	210.84	183.34
88	326.37	283.80	409.29	355.90	296.28	257.63	226.79	197.21	212.55	184.83
89	328.99	286.08	412.59	358.78	298.66	259.71	228.62	198.80	214.27	186.32
90+	331.63	288.37	415.89	361.64	301.05	261.78	230.44	200.39	215.98	187.81

Plan C		Plan F	
Male	Female	Male	Female
204.24	177.60	227.09	197.46
204.24	177.60	227.09	197.46
204.24	177.60	227.09	197.46
215.47	187.37	239.57	208.33
226.70	197.13	252.07	219.19
237.94	206.91	264.55	230.05
248.16	215.79	275.91	239.92
258.37	224.66	287.26	249.79
268.57	233.55	298.62	259.67
278.79	242.43	309.98	269.54
289.01	251.31	321.33	279.41
298.19	259.29	331.55	288.30
307.39	267.29	341.76	297.19
316.57	275.28	351.98	306.08
325.76	283.27	362.20	314.96
334.95	291.27	372.43	323.85
342.11	297.48	380.37	330.75
349.26	303.70	388.31	337.66
356.40	309.92	396.26	344.57
363.54	316.13	404.21	351.49
370.70	322.35	412.16	358.40
373.76	325.01	415.56	361.36
376.83	327.67	418.97	364.33
379.89	330.34	422.37	367.28
382.96	333.00	425.78	370.24
386.02	335.67	429.19	373.21

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025. Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 1 (ZIP Codes 680-681)

Age	Plan A**		Plan B		Plan G		Plan L		Plan N		Plan C		Plan F	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	356.09	309.65												
65	237.39	206.43	297.71	258.88	215.51	187.40	164.96	143.45	154.61	134.44	276.33	240.28	307.23	267.16
66	237.39	206.43	297.71	258.88	215.51	187.40	164.96	143.45	154.61	134.44	276.33	240.28	307.23	267.16
67	237.39	206.43	297.71	258.88	215.51	187.40	164.96	143.45	154.61	134.44	276.33	240.28	307.23	267.16
68	250.45	217.78	314.08	273.11	227.35	197.70	174.03	151.33	163.12	141.84	291.53	253.50	324.13	281.85
69	263.50	229.13	330.46	287.36	239.21	208.01	183.10	159.22	171.62	149.24	306.72	266.71	341.03	296.55
70	276.57	240.49	346.83	301.60	251.06	218.31	192.18	167.11	180.11	156.62	321.92	279.93	357.93	311.24
71	288.43	250.81	361.72	314.54	261.84	227.69	200.43	174.29	187.85	163.35	335.74	291.95	373.29	324.60
72	300.30	261.13	376.60	327.48	272.62	237.06	208.67	181.45	195.58	170.07	349.55	303.96	388.65	337.95
73	312.17	271.45	391.49	340.42	283.39	246.42	216.93	188.63	203.31	176.79	363.37	315.97	404.01	351.32
74	324.04	281.78	406.37	353.37	294.17	255.80	225.17	195.80	211.05	183.52	377.19	327.99	419.38	364.68
75	335.90	292.09	421.26	366.32	304.93	265.16	233.42	202.98	218.77	190.24	391.01	340.01	434.73	378.03
76	346.60	301.39	434.66	377.96	314.63	273.59	240.85	209.43	225.73	196.29	403.43	350.81	448.56	390.06
77	357.28	310.67	448.05	389.61	324.33	282.03	248.27	215.89	232.69	202.34	415.87	361.63	462.38	402.07
78	367.95	319.96	461.45	401.26	334.03	290.46	255.70	222.35	239.64	208.38	428.31	372.44	476.22	414.10
79	378.65	329.26	474.85	412.91	343.73	298.90	263.11	228.79	246.60	214.44	440.74	383.25	490.04	426.12
80	389.33	338.54	488.24	424.56	353.43	307.33	270.54	235.25	253.56	220.49	453.17	394.06	503.87	438.15
81	397.63	345.77	498.67	433.62	360.97	313.89	276.31	240.27	258.98	225.20	462.85	402.48	514.61	447.49
82	405.93	352.99	509.08	442.68	368.52	320.45	282.08	245.29	264.38	229.89	472.52	410.89	525.37	456.84
83	414.25	360.22	519.51	451.75	376.06	327.01	287.86	250.31	269.79	234.60	482.20	419.30	536.12	466.19
84	422.56	367.44	529.93	460.81	383.60	333.56	293.63	255.33	275.21	239.31	491.86	427.70	546.87	475.54
85	430.86	374.66	540.34	469.86	391.15	340.13	299.41	260.35	280.61	244.01	501.53	436.12	557.63	484.90
86	434.43	377.76	544.81	473.75	394.38	342.94	301.88	262.51	282.94	246.03	505.68	439.72	562.24	488.90
87	437.98	380.86	549.27	477.63	397.60	345.74	304.36	264.66	285.26	248.05	509.82	443.33	566.85	492.91
88	441.55	383.96	553.75	481.52	400.85	348.56	306.83	266.81	287.57	250.06	513.97	446.93	571.45	496.91
89	445.11	387.05	558.21	485.40	404.08	351.37	309.31	268.96	289.90	252.08	518.12	450.54	576.06	500.92
90+	448.68	390.15	562.67	489.28	407.30	354.18	311.78	271.11	292.21	254.09	522.26	454.14	580.67	504.93

Plan C and Plan F: Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025.
Premium payment may be made monthly.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 1 (ZIP Codes 680-681) – Household Discount Applied*

Age	Plan A**		Plan B		Plan G		Plan L		Plan N		Plan C		Plan F	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	302.67	263.21												
65	201.78	175.47	253.05	220.05	183.18	159.29	140.22	121.93	131.42	114.27	234.88	204.24	261.15	227.09
66	201.78	175.47	253.05	220.05	183.18	159.29	140.22	121.93	131.42	114.27	234.88	204.24	261.15	227.09
67	201.78	175.47	253.05	220.05	183.18	159.29	140.22	121.93	131.42	114.27	234.88	204.24	261.15	227.09
68	212.88	185.11	266.97	232.14	193.25	168.04	147.93	128.63	138.65	120.56	247.80	215.47	275.51	239.57
69	223.97	194.76	280.89	244.26	203.33	176.81	155.63	135.34	145.88	126.85	260.71	226.70	289.88	252.07
70	235.08	204.42	294.81	256.36	213.40	185.56	163.35	142.04	153.09	133.13	273.63	237.94	304.24	264.55
71	245.17	213.19	307.46	267.36	222.56	193.54	170.37	148.15	159.67	138.85	285.38	248.16	317.30	275.91
72	255.25	221.96	320.11	278.36	231.73	201.50	177.37	154.23	166.24	144.56	297.12	258.37	330.35	287.26
73	265.34	230.73	332.77	289.36	240.88	209.46	184.39	160.34	172.81	150.27	308.86	268.57	343.41	298.62
74	275.43	239.51	345.41	300.36	250.04	217.43	191.39	166.43	179.39	155.99	320.61	278.79	356.47	309.98
75	285.51	248.28	358.07	311.37	259.19	225.39	198.41	172.53	185.95	161.70	332.36	289.01	369.52	321.33
76	294.61	256.18	369.46	321.27	267.44	232.55	204.72	178.02	191.87	166.85	342.92	298.19	381.28	331.55
77	303.69	264.07	380.84	331.17	275.68	239.73	211.03	183.51	197.79	171.99	353.49	307.39	393.02	341.76
78	312.76	271.97	392.23	341.07	283.93	246.89	217.34	189.00	203.69	177.12	364.06	316.57	404.79	351.98
79	321.85	279.87	403.62	350.97	292.17	254.06	223.64	194.47	209.61	182.27	374.63	325.76	416.53	362.20
80	330.93	287.76	415.00	360.88	300.42	261.23	229.96	199.96	215.53	187.42	385.19	334.95	428.29	372.43
81	337.99	293.90	423.87	368.58	306.82	266.81	234.86	204.23	220.13	191.42	393.42	342.11	437.42	380.37
82	345.04	300.04	432.72	376.28	313.24	272.38	239.77	208.50	224.72	195.41	401.64	349.26	446.56	388.31
83	352.11	306.19	441.58	383.99	319.65	277.96	244.68	212.76	229.32	199.41	409.87	356.40	455.70	396.26
84	359.18	312.32	450.44	391.69	326.06	283.53	249.59	217.03	233.93	203.41	418.08	363.54	464.84	404.21
85	366.23	318.46	459.29	399.38	332.48	289.11	254.50	221.30	238.52	207.41	426.30	370.70	473.99	412.16
86	369.27	321.10	463.09	402.69	335.22	291.50	256.60	223.13	240.50	209.13	429.83	373.76	477.90	415.56
87	372.28	323.73	466.88	405.99	337.96	293.88	258.71	224.96	242.47	210.84	433.35	376.83	481.82	418.97
88	375.32	326.37	470.69	409.29	340.72	296.28	260.81	226.79	244.43	212.55	436.87	379.89	485.73	422.37
89	378.34	328.99	474.48	412.59	343.47	298.66	262.91	228.62	246.41	214.27	440.40	382.96	489.65	425.78
90+	381.38	331.63	478.27	415.89	346.20	301.05	265.01	230.44	248.38	215.98	443.92	386.02	493.57	429.19

Plan C and Plan F: Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025. Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 2 (ZIP Codes 683-685)

Age	Plan A**		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	325.94	283.43								
65	217.29	188.95	272.50	236.96	197.26	171.53	151.00	131.30	141.52	123.06
66	217.29	188.95	272.50	236.96	197.26	171.53	151.00	131.30	141.52	123.06
67	217.29	188.95	272.50	236.96	197.26	171.53	151.00	131.30	141.52	123.06
68	229.24	199.34	287.49	249.99	208.10	180.96	159.30	138.52	149.30	129.83
69	241.19	209.73	302.48	263.03	218.96	190.40	167.60	145.74	157.09	136.60
70	253.15	220.13	317.47	276.06	229.80	199.83	175.90	152.96	164.86	143.36
71	264.01	229.57	331.10	287.91	239.67	208.41	183.46	159.53	171.95	149.52
72	274.87	239.02	344.71	299.75	249.54	216.99	191.00	166.09	179.02	155.67
73	285.74	248.47	358.34	311.60	259.39	225.56	198.56	172.66	186.09	161.82
74	296.61	257.92	371.97	323.45	269.26	234.14	206.10	179.22	193.18	167.98
75	307.46	267.36	385.60	335.30	279.12	242.71	213.66	185.79	200.25	174.13
76	317.25	275.87	397.85	345.96	287.99	250.43	220.46	191.70	206.62	179.67
77	327.03	284.37	410.11	356.62	296.87	258.15	227.25	197.61	212.99	185.21
78	336.80	292.87	422.38	367.29	305.75	265.87	234.05	203.52	219.35	190.74
79	346.59	301.38	434.64	377.95	314.63	273.59	240.83	209.42	225.72	196.28
80	356.36	309.88	446.90	388.61	323.51	281.31	247.63	215.33	232.09	201.82
81	363.96	316.49	456.45	396.91	330.41	287.31	252.92	219.93	237.05	206.13
82	371.57	323.10	465.98	405.20	337.32	293.32	258.20	224.52	241.99	210.43
83	379.18	329.72	475.53	413.50	344.22	299.32	263.49	229.12	246.95	214.74
84	386.78	336.33	485.06	421.79	351.12	305.32	268.77	233.71	251.91	219.05
85	394.38	342.94	494.59	430.08	358.03	311.33	274.06	238.31	256.85	223.35
86	397.65	345.78	498.69	433.64	360.99	313.90	276.32	240.28	258.98	225.20
87	400.90	348.61	502.77	437.19	363.94	316.47	278.59	242.25	261.11	227.05
88	404.17	351.45	506.86	440.75	366.91	319.05	280.85	244.22	263.22	228.89
89	407.42	354.28	510.95	444.30	369.86	321.62	283.12	246.19	265.35	230.74
90+	410.69	357.12	515.03	447.85	372.82	324.19	285.38	248.16	267.47	232.58

Age	Plan C		Plan F	
	Male	Female	Male	Female
0-64				
65	252.93	219.94	281.22	244.54
66	252.93	219.94	281.22	244.54
67	252.93	219.94	281.22	244.54
68	266.85	232.04	296.69	257.99
69	280.75	244.13	312.16	271.44
70	294.66	256.23	327.62	284.89
71	307.31	267.23	341.69	297.12
72	319.95	278.22	355.74	309.34
73	332.60	289.22	369.81	321.57
74	345.25	300.22	383.87	333.80
75	357.90	311.22	397.92	346.02
76	369.28	321.11	410.58	357.03
77	380.66	331.01	423.23	368.03
78	392.05	340.91	435.90	379.04
79	403.42	350.80	448.55	390.04
80	414.81	360.70	461.21	401.05
81	423.66	368.40	471.04	409.60
82	432.52	376.10	480.88	418.16
83	441.37	383.80	490.73	426.72
84	450.21	391.49	500.57	435.28
85	459.07	399.19	510.42	443.84
86	462.86	402.49	514.64	447.51
87	466.66	405.79	518.86	451.18
88	470.45	409.09	523.07	454.84
89	474.25	412.39	527.29	458.51
90+	478.04	415.69	531.51	462.18

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025.
Premium payment may be made monthly.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 2 (ZIP Codes 683-685) – Household Discount Applied*

Age	Plan A**		Plan B		Plan G		Plan L		Plan N		Plan C		Plan F	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	277.05	240.92												
65	184.70	160.61	231.62	201.42	167.67	145.80	128.35	111.60	120.29	104.60	214.99	186.95	239.04	207.86
66	184.70	160.61	231.62	201.42	167.67	145.80	128.35	111.60	120.29	104.60	214.99	186.95	239.04	207.86
67	184.70	160.61	231.62	201.42	167.67	145.80	128.35	111.60	120.29	104.60	214.99	186.95	239.04	207.86
68	194.85	169.44	244.37	212.49	176.88	153.82	135.40	117.74	126.90	110.36	226.82	197.23	252.19	219.29
69	205.01	178.27	257.11	223.58	186.12	161.84	142.46	123.88	133.53	116.11	238.64	207.51	265.34	230.72
70	215.18	187.11	269.85	234.65	195.33	169.86	149.51	130.02	140.13	121.86	250.46	217.80	278.48	242.16
71	224.41	195.13	281.43	244.72	203.72	177.15	155.94	135.60	146.16	127.09	261.21	227.15	290.44	252.55
72	233.64	203.17	293.00	254.79	212.11	184.44	162.35	141.18	152.17	132.32	271.96	236.49	302.38	262.94
73	242.88	211.20	304.59	264.86	220.48	191.73	168.78	146.76	158.18	137.55	282.71	245.84	314.34	273.33
74	252.12	219.23	316.17	274.93	228.87	199.02	175.18	152.34	164.20	142.78	293.46	255.19	326.29	283.73
75	261.34	227.26	327.76	285.00	237.25	206.30	181.61	157.92	170.21	148.01	304.21	264.54	338.23	294.12
76	269.66	234.49	338.17	294.07	244.79	212.87	187.39	162.94	175.63	152.72	313.89	272.94	348.99	303.48
77	277.98	241.71	348.59	303.13	252.34	219.43	193.16	167.97	181.04	157.43	323.56	281.36	359.75	312.83
78	286.28	248.94	359.02	312.20	259.89	225.99	198.94	172.99	186.45	162.13	333.24	289.77	370.51	322.18
79	294.60	256.17	369.44	321.26	267.44	232.55	204.71	178.01	191.86	166.84	342.91	298.18	381.27	331.53
80	302.91	263.40	379.86	330.32	274.98	239.11	210.49	183.03	197.28	171.55	352.59	306.59	392.03	340.89
81	309.37	269.02	387.98	337.37	280.85	244.21	214.98	186.94	201.49	175.21	360.11	313.14	400.38	348.16
82	315.83	274.63	396.08	344.42	286.72	249.32	219.47	190.84	205.69	178.87	367.64	319.68	408.75	355.44
83	322.30	280.26	404.20	351.47	292.59	254.42	223.97	194.75	209.91	182.53	375.16	326.23	417.12	362.71
84	328.76	285.88	412.30	358.52	298.45	259.52	228.45	198.65	214.12	186.19	382.68	332.77	425.48	369.99
85	335.22	291.50	420.40	365.57	304.33	264.63	232.95	202.56	218.32	189.85	390.21	339.31	433.86	377.26
86	338.00	293.91	423.89	368.59	306.84	266.81	234.87	204.24	220.13	191.42	393.43	342.12	437.44	380.38
87	340.76	296.32	427.35	371.61	309.35	269.00	236.80	205.91	221.94	192.99	396.66	344.92	441.03	383.50
88	343.54	298.73	430.83	374.64	311.87	271.19	238.72	207.59	223.74	194.56	399.88	347.73	444.61	386.61
89	346.31	301.14	434.31	377.65	314.38	273.38	240.65	209.26	225.55	196.13	403.11	350.53	448.20	389.73
90+	349.09	303.55	437.78	380.67	316.90	275.56	242.57	210.94	227.35	197.69	406.33	353.34	451.78	392.85

Plan C and Plan F: Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025. Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 2 (ZIP Codes 683-685)

Age	Plan A**		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	374.84	325.94								
65	249.89	217.29	313.38	272.50	226.85	197.26	173.64	151.00	162.75	141.52
66	249.89	217.29	313.38	272.50	226.85	197.26	173.64	151.00	162.75	141.52
67	249.89	217.29	313.38	272.50	226.85	197.26	173.64	151.00	162.75	141.52
68	263.63	229.24	330.61	287.49	239.32	208.10	183.19	159.30	171.70	149.30
69	277.37	241.19	347.86	302.48	251.80	218.96	192.74	167.60	180.65	157.09
70	291.12	253.15	365.09	317.47	264.28	229.80	202.29	175.90	189.59	164.86
71	303.61	264.01	380.76	331.10	275.62	239.67	210.98	183.46	197.74	171.95
72	316.10	274.87	396.42	344.71	286.97	249.54	219.65	191.00	205.87	179.02
73	328.60	285.74	412.09	358.34	298.30	259.39	228.34	198.56	214.01	186.09
74	341.10	296.61	427.76	371.97	309.65	269.26	237.02	206.10	222.15	193.18
75	353.58	307.46	443.43	385.60	320.98	279.12	245.71	213.66	230.29	200.25
76	364.84	317.25	457.53	397.85	331.19	287.99	253.52	220.46	237.61	206.62
77	376.08	327.03	471.63	410.11	341.40	296.87	261.34	227.25	244.94	212.99
78	387.32	336.80	485.74	422.38	351.61	305.75	269.16	234.05	252.25	219.35
79	398.58	346.59	499.84	434.64	361.82	314.63	276.96	240.83	259.58	225.72
80	409.82	356.36	513.94	446.90	372.03	323.51	284.77	247.63	266.91	232.09
81	418.56	363.96	524.91	456.45	379.97	330.41	290.86	252.92	272.61	237.05
82	427.30	371.57	535.88	465.98	387.92	337.32	296.93	258.20	278.29	241.99
83	436.05	379.18	546.85	475.53	395.85	344.22	303.01	263.49	283.99	246.95
84	444.80	386.78	557.82	485.06	403.79	351.12	309.08	268.77	289.69	251.91
85	453.54	394.38	568.78	494.59	411.73	358.03	315.16	274.06	295.38	256.85
86	457.29	397.65	573.49	498.69	415.13	360.99	317.77	276.32	297.83	258.98
87	461.04	400.90	578.18	502.77	418.53	363.94	320.38	278.59	300.27	261.11
88	464.79	404.17	582.89	506.86	421.94	366.91	322.98	280.85	302.71	263.22
89	468.54	407.42	587.59	510.95	425.34	369.86	325.59	283.12	305.15	265.35
90+	472.29	410.69	592.28	515.03	428.74	372.82	328.19	285.38	307.59	267.47

Age	Plan C		Plan F	
	Male	Female	Male	Female
0-64				
65	290.87	252.93	323.40	281.22
66	290.87	252.93	323.40	281.22
67	290.87	252.93	323.40	281.22
68	306.87	266.85	341.19	296.69
69	322.86	280.75	358.98	312.16
70	338.86	294.66	376.77	327.62
71	353.41	307.31	392.94	341.69
72	367.95	319.95	409.10	355.74
73	382.49	332.60	425.28	369.81
74	397.04	345.25	441.45	383.87
75	411.59	357.90	457.61	397.92
76	424.67	369.28	472.17	410.58
77	437.76	380.66	486.72	423.23
78	450.85	392.05	501.28	435.90
79	463.93	403.42	515.83	448.55
80	477.03	414.81	530.39	461.21
81	487.21	423.66	541.70	471.04
82	497.39	432.52	553.02	480.88
83	507.58	441.37	564.34	490.73
84	517.75	450.21	575.66	500.57
85	527.93	459.07	586.98	510.42
86	532.29	462.86	591.83	514.64
87	536.66	466.66	596.69	518.86
88	541.02	470.45	601.53	523.07
89	545.39	474.25	606.38	527.29
90+	549.75	478.04	611.23	531.51

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025.
Premium payment may be made monthly.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 2 (ZIP Codes 683-685) – Household Discount Applied*

Age	Plan A**		Plan B		Plan G		Plan L		Plan N		Plan C		Plan F	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	318.62	277.05												
65	212.41	184.70	266.37	231.62	192.82	167.67	147.59	128.35	138.34	120.29	247.24	214.99	274.89	239.04
66	212.41	184.70	266.37	231.62	192.82	167.67	147.59	128.35	138.34	120.29	247.24	214.99	274.89	239.04
67	212.41	184.70	266.37	231.62	192.82	167.67	147.59	128.35	138.34	120.29	247.24	214.99	274.89	239.04
68	224.09	194.85	281.02	244.37	203.42	176.88	155.71	135.40	145.94	126.90	260.84	226.82	290.01	252.19
69	235.76	205.01	295.68	257.11	214.03	186.12	163.83	142.46	153.55	133.53	274.43	238.64	305.13	265.34
70	247.45	215.18	310.33	269.85	224.64	195.33	171.95	149.51	161.15	140.13	288.03	250.46	320.25	278.48
71	258.07	224.41	323.65	281.43	234.28	203.72	179.33	155.94	168.08	146.16	300.40	261.21	334.00	290.44
72	268.68	233.64	336.96	293.00	243.92	212.11	186.70	162.35	174.99	152.17	312.76	271.96	347.73	302.38
73	279.31	242.88	350.28	304.59	253.55	220.48	194.09	168.78	181.91	158.18	325.12	282.71	361.49	314.34
74	289.93	252.12	363.60	316.17	263.20	228.87	201.47	175.18	188.83	164.20	337.48	293.46	375.23	326.29
75	300.54	261.34	376.92	327.76	272.83	237.25	208.85	181.61	195.75	170.21	349.85	304.21	388.97	338.23
76	310.11	269.66	388.90	338.17	281.51	244.79	215.49	187.39	201.97	175.63	360.97	313.89	401.34	348.99
77	319.67	277.98	400.89	348.59	290.19	252.34	222.14	193.16	208.20	181.04	372.10	323.56	413.71	359.75
78	329.22	286.28	412.88	359.02	298.87	259.89	228.79	198.94	214.41	186.45	383.22	333.24	426.09	370.51
79	338.79	294.60	424.86	369.44	307.55	267.44	235.42	204.71	220.64	191.86	394.34	342.91	438.46	381.27
80	348.35	302.91	436.85	379.86	316.23	274.98	242.05	210.49	226.87	197.28	405.48	352.59	450.83	392.03
81	355.78	309.37	446.17	387.98	322.97	280.85	247.23	214.98	231.72	201.49	414.13	360.11	460.44	400.38
82	363.20	315.83	455.50	396.08	329.73	286.72	252.39	219.47	236.55	205.69	422.78	367.64	470.07	408.75
83	370.64	322.30	464.82	404.20	336.47	292.59	257.56	223.97	241.39	209.91	431.44	375.16	479.69	417.12
84	378.08	328.76	474.15	412.30	343.22	298.45	262.72	228.45	246.24	214.12	440.09	382.68	489.31	425.48
85	385.51	335.22	483.46	420.40	349.97	304.33	267.89	232.95	251.07	218.32	448.74	390.21	498.93	433.86
86	388.70	338.00	487.47	423.89	352.86	306.84	270.10	234.87	253.16	220.13	452.45	393.43	503.06	437.44
87	391.88	340.76	491.45	427.35	355.75	309.35	272.32	236.80	255.23	221.94	456.16	396.66	507.19	441.03
88	395.07	343.54	495.46	430.83	358.65	311.87	274.53	238.72	257.30	223.74	459.87	399.88	511.30	444.61
89	398.26	346.31	499.45	434.31	361.54	314.38	276.75	240.65	259.38	225.55	463.58	403.11	515.42	448.20
90+	401.45	349.09	503.44	437.78	364.43	316.90	278.96	242.57	261.45	227.35	467.29	406.33	519.55	451.78

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025. Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 3 (ZIP Codes 686-689)

Age	Plan A**		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	332.46	289.10								
65	221.64	192.73	277.95	241.70	201.20	174.96	154.01	133.93	144.35	125.52
66	221.64	192.73	277.95	241.70	201.20	174.96	154.01	133.93	144.35	125.52
67	221.64	192.73	277.95	241.70	201.20	174.96	154.01	133.93	144.35	125.52
68	233.83	203.33	293.24	254.99	212.27	184.58	162.48	141.29	152.29	132.43
69	246.01	213.92	308.53	268.29	223.34	194.21	170.95	148.65	160.23	139.33
70	258.21	224.53	323.82	281.58	234.40	203.83	179.42	156.02	168.16	146.23
71	269.29	234.16	337.72	293.67	244.46	212.58	187.13	162.72	175.39	152.51
72	280.37	243.80	351.61	305.75	254.53	221.33	194.82	169.41	182.60	158.78
73	291.46	253.44	365.51	317.83	264.58	230.07	202.53	176.11	189.81	165.06
74	302.54	263.08	379.41	329.92	274.65	238.82	210.23	182.80	197.04	171.34
75	313.61	272.71	393.31	342.01	284.70	247.56	217.93	189.51	204.25	177.61
76	323.60	281.39	405.81	352.88	293.75	255.44	224.86	195.53	210.75	183.26
77	333.57	290.06	418.32	363.75	302.81	263.31	231.80	201.56	217.25	188.91
78	343.54	298.73	430.83	374.64	311.87	271.19	238.73	207.59	223.74	194.55
79	353.52	307.41	443.34	385.51	320.92	279.06	245.65	213.61	230.24	200.21
80	363.49	316.08	455.84	396.38	329.98	286.94	252.58	219.64	236.73	205.86
81	371.24	322.82	465.58	404.85	337.01	293.06	257.98	224.33	241.79	210.25
82	379.00	329.56	475.30	413.30	344.06	299.19	263.36	229.01	246.83	214.64
83	386.76	336.31	485.04	421.77	351.10	305.31	268.76	233.70	251.89	219.03
84	394.52	343.06	494.76	430.23	358.14	311.43	274.14	238.38	256.95	223.43
85	402.27	349.80	504.48	438.68	365.19	317.56	279.54	243.08	261.99	227.82
86	405.60	352.70	508.66	442.31	368.20	320.18	281.85	245.09	264.16	229.70
87	408.92	355.58	512.82	445.93	371.22	322.80	284.16	247.10	266.33	231.59
88	412.25	358.48	517.00	449.57	374.25	325.43	286.47	249.10	268.49	233.47
89	415.57	361.37	521.16	453.19	377.26	328.05	288.78	251.11	270.66	235.35
90+	418.90	364.26	525.33	456.81	380.27	330.67	291.09	253.12	272.82	237.23

Age	Plan C		Plan F	
	Male	Female	Male	Female
0-64				
65	257.99	224.34	286.85	249.43
66	257.99	224.34	286.85	249.43
67	257.99	224.34	286.85	249.43
68	272.18	236.68	302.62	263.15
69	286.36	249.01	318.40	276.87
70	300.56	261.35	334.18	290.59
71	313.46	272.57	348.52	303.06
72	326.35	283.78	362.86	315.53
73	339.26	295.00	377.20	328.00
74	352.16	306.22	391.55	340.48
75	365.06	317.44	405.88	352.94
76	376.66	327.53	418.80	364.17
77	388.27	337.63	431.70	375.39
78	399.89	347.73	444.61	386.62
79	411.49	357.82	457.52	397.84
80	423.10	367.91	470.43	409.07
81	432.13	375.77	480.46	417.79
82	441.17	383.62	490.50	426.52
83	450.20	391.48	500.54	435.25
84	459.22	399.32	510.58	443.99
85	468.25	407.17	520.62	452.72
86	472.12	410.54	524.93	456.46
87	475.99	413.91	529.23	460.20
88	479.86	417.27	533.53	463.94
89	483.73	420.64	537.83	467.68
90+	487.60	424.00	542.14	471.42

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025.
Premium payment may be made monthly.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 3 (ZIP Codes 686-689) – Household Discount Applied*

Age	Plan A**		Plan B		Plan G		Plan L		Plan N		Plan C		Plan F	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	282.58	245.73												
65	188.39	163.82	236.26	205.44	171.02	148.72	130.91	113.84	122.70	106.69	219.29	190.69	243.82	212.02
66	188.39	163.82	236.26	205.44	171.02	148.72	130.91	113.84	122.70	106.69	219.29	190.69	243.82	212.02
67	188.39	163.82	236.26	205.44	171.02	148.72	130.91	113.84	122.70	106.69	219.29	190.69	243.82	212.02
68	198.76	172.83	249.25	216.74	180.43	156.89	138.11	120.10	129.45	112.57	231.35	201.18	257.23	223.68
69	209.11	181.83	262.25	228.05	189.84	165.08	145.31	126.35	136.20	118.43	243.41	211.66	270.64	235.34
70	219.48	190.85	275.25	239.34	199.24	173.26	152.51	132.62	142.94	124.30	255.48	222.15	284.05	247.00
71	228.90	199.04	287.06	249.62	207.79	180.69	159.06	138.31	149.08	129.63	266.44	231.68	296.24	257.60
72	238.31	207.23	298.87	259.89	216.35	188.13	165.60	144.00	155.21	134.96	277.40	241.21	308.43	268.20
73	247.74	215.42	310.68	270.16	224.89	195.56	172.15	149.69	161.34	140.30	288.37	250.75	320.62	278.80
74	257.16	223.62	322.50	280.43	233.45	203.00	178.70	155.38	167.48	145.64	299.34	260.29	332.82	289.41
75	266.57	231.80	334.31	290.71	241.99	210.43	185.24	161.08	173.61	150.97	310.30	269.82	345.00	300.00
76	275.06	239.18	344.94	299.95	249.69	217.12	191.13	166.20	179.14	155.77	320.16	278.40	355.98	309.54
77	283.53	246.55	355.57	309.19	257.39	223.81	197.03	171.33	184.66	160.57	330.03	286.99	366.94	319.08
78	292.01	253.92	366.21	318.44	265.09	230.51	202.92	176.45	190.18	165.37	339.91	295.57	377.92	328.63
79	300.49	261.30	376.84	327.68	272.78	237.20	208.80	181.57	195.70	170.18	349.77	304.15	388.89	338.16
80	308.97	268.67	387.46	336.92	280.48	243.90	214.69	186.69	201.22	174.98	359.63	312.72	399.87	347.71
81	315.55	274.40	395.74	344.12	286.46	249.10	219.28	190.68	205.52	178.71	367.31	319.40	408.39	355.12
82	322.15	280.13	404.00	351.30	292.45	254.31	223.86	194.66	209.81	182.44	374.99	326.08	416.92	362.54
83	328.75	285.86	412.28	358.50	298.43	259.51	228.45	198.64	214.11	186.18	382.67	332.76	425.46	369.96
84	335.34	291.60	420.55	365.70	304.42	264.72	233.02	202.62	218.41	189.92	390.34	339.42	433.99	377.39
85	341.93	297.33	428.81	372.88	310.41	269.93	237.61	206.62	222.69	193.65	398.01	346.09	442.53	384.81
86	344.76	299.79	432.36	375.96	312.97	272.15	239.57	208.33	224.54	195.24	401.30	348.96	446.19	387.99
87	347.58	302.24	435.90	379.04	315.54	274.38	241.54	210.03	226.38	196.85	404.59	351.82	449.85	391.17
88	350.41	304.71	439.45	382.13	318.11	276.62	243.50	211.73	228.22	198.45	407.88	354.68	453.50	394.35
89	353.23	307.16	442.99	385.21	320.67	278.84	245.46	213.44	230.06	200.05	411.17	357.54	457.16	397.53
90+	356.06	309.62	446.53	388.29	323.23	281.07	247.43	215.15	231.90	201.65	414.46	360.40	460.82	400.71

Plan C and Plan F: Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025. Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 3 (ZIP Codes 686-689)

Age	Plan A**		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	382.32	332.46								
65	254.88	221.64	319.65	277.95	231.39	201.20	177.12	154.01	166.00	144.35
66	254.88	221.64	319.65	277.95	231.39	201.20	177.12	154.01	166.00	144.35
67	254.88	221.64	319.65	277.95	231.39	201.20	177.12	154.01	166.00	144.35
68	268.90	233.83	337.22	293.24	244.11	212.27	186.86	162.48	175.13	152.29
69	282.92	246.01	354.81	308.53	256.84	223.34	196.60	170.95	184.27	160.23
70	296.94	258.21	372.39	323.82	269.56	234.40	206.34	179.42	193.39	168.16
71	309.68	269.29	388.38	337.72	281.13	244.46	215.20	187.13	201.70	175.39
72	322.43	280.37	404.35	351.61	292.71	254.53	224.05	194.82	209.99	182.60
73	335.17	291.46	420.33	365.51	304.27	264.58	232.91	202.53	218.29	189.81
74	347.92	302.54	436.32	379.41	315.84	274.65	241.76	210.23	226.60	197.04
75	360.66	313.61	452.30	393.31	327.40	284.70	250.62	217.93	234.89	204.25
76	372.13	323.60	466.68	405.81	337.82	293.75	258.59	224.86	242.37	210.75
77	383.60	333.57	481.06	418.32	348.23	302.81	266.57	231.80	249.84	217.25
78	395.07	343.54	495.46	430.83	358.65	311.87	274.54	238.73	257.30	223.74
79	406.55	353.52	509.84	443.34	369.06	320.92	282.50	245.65	264.77	230.24
80	418.01	363.49	524.22	455.84	379.47	329.98	290.47	252.58	272.25	236.73
81	426.93	371.24	535.41	465.58	387.57	337.01	296.67	257.98	278.06	241.79
82	435.85	379.00	546.59	475.30	395.67	344.06	302.87	263.36	283.86	246.83
83	444.78	386.76	557.79	485.04	403.77	351.10	309.07	268.76	289.67	251.89
84	453.69	394.52	568.97	494.76	411.86	358.14	315.26	274.14	295.49	256.95
85	462.61	402.27	580.16	504.48	419.97	365.19	321.47	279.54	301.29	261.99
86	466.44	405.60	584.96	508.66	423.44	368.20	324.13	281.85	303.78	264.16
87	470.26	408.92	589.75	512.82	426.90	371.22	326.78	284.16	306.28	266.33
88	474.09	412.25	594.55	517.00	430.38	374.25	329.44	286.47	308.76	268.49
89	477.91	415.57	599.34	521.16	433.85	377.26	332.10	288.78	311.26	270.66
90+	481.74	418.90	604.13	525.33	437.32	380.27	334.76	291.09	313.74	272.82

Age	Plan C		Plan F	
	Male	Female	Male	Female
0-64				
65	296.69	257.99	329.87	286.85
66	296.69	257.99	329.87	286.85
67	296.69	257.99	329.87	286.85
68	313.01	272.18	348.02	302.62
69	329.32	286.36	366.16	318.40
70	345.64	300.56	384.30	334.18
71	360.48	313.46	400.80	348.52
72	375.30	326.35	417.28	362.86
73	390.14	339.26	433.78	377.20
74	404.98	352.16	450.28	391.55
75	419.82	365.06	466.76	405.88
76	433.16	376.66	481.62	418.80
77	446.52	388.27	496.45	431.70
78	459.87	399.89	511.31	444.61
79	473.21	411.49	526.14	457.52
80	486.57	423.10	541.00	470.43
81	496.95	432.13	552.53	480.46
82	507.34	441.17	564.08	490.50
83	517.73	450.20	575.62	500.54
84	528.10	459.22	587.17	510.58
85	538.49	468.25	598.72	520.62
86	542.94	472.12	603.67	524.93
87	547.39	475.99	608.62	529.23
88	551.84	479.86	613.56	533.53
89	556.29	483.73	618.51	537.83
90+	560.75	487.60	623.46	542.14

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025.
Premium payment may be made monthly.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 3 (ZIP Codes 686-689) – Household Discount Applied*

Age	Plan A**		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	324.97	282.58								
65	216.65	188.39	271.70	236.26	196.68	171.02	150.55	130.91	141.10	122.70
66	216.65	188.39	271.70	236.26	196.68	171.02	150.55	130.91	141.10	122.70
67	216.65	188.39	271.70	236.26	196.68	171.02	150.55	130.91	141.10	122.70
68	228.56	198.76	286.64	249.25	207.49	180.43	158.83	138.11	148.86	129.45
69	240.48	209.11	301.59	262.25	218.31	189.84	167.11	145.31	156.63	136.20
70	252.40	219.48	316.53	275.25	229.13	199.24	175.39	152.51	164.38	142.94
71	263.23	228.90	330.12	287.06	238.96	207.79	182.92	159.06	171.44	149.08
72	274.07	238.31	343.70	298.87	248.80	216.35	190.44	165.60	178.49	155.21
73	284.89	247.74	357.28	310.68	258.63	224.89	197.97	172.15	185.55	161.34
74	295.73	257.16	370.87	322.50	268.46	233.45	205.50	178.70	192.61	167.48
75	306.56	266.57	384.45	334.31	278.29	241.99	213.03	185.24	199.66	173.61
76	316.31	275.06	396.68	344.94	287.15	249.69	219.80	191.13	206.01	179.14
77	326.06	283.53	408.90	355.57	296.00	257.39	226.58	197.03	212.36	184.66
78	335.81	292.01	421.14	366.21	304.85	265.09	233.36	202.92	218.70	190.18
79	345.57	300.49	433.36	376.84	313.70	272.78	240.12	208.80	225.05	195.70
80	355.31	308.97	445.59	387.46	322.55	280.48	246.90	214.69	231.41	201.22
81	362.89	315.55	455.10	395.74	329.43	286.46	252.17	219.28	236.35	205.52
82	370.47	322.15	464.60	404.00	336.32	292.45	257.44	223.86	241.28	209.81
83	378.06	328.75	474.12	412.28	343.20	298.43	262.71	228.45	246.22	214.11
84	385.64	335.34	483.62	420.55	350.08	304.42	267.97	233.02	251.17	218.41
85	393.22	341.93	493.14	428.81	356.97	310.41	273.25	237.61	256.10	222.69
86	396.47	344.76	497.22	432.36	359.92	312.97	275.51	239.57	258.21	224.54
87	399.72	347.58	501.29	435.90	362.86	315.54	277.76	241.54	260.34	226.38
88	402.98	350.41	505.37	439.45	365.82	318.11	280.02	243.50	262.45	228.22
89	406.22	353.23	509.44	442.99	368.77	320.67	282.28	245.46	264.57	230.06
90+	409.48	356.06	513.51	446.53	371.72	323.23	284.55	247.43	266.68	231.90

Plan C		Plan F	
Male	Female	Male	Female
252.19	219.29	280.39	243.82
252.19	219.29	280.39	243.82
252.19	219.29	280.39	243.82
266.06	231.35	295.82	257.23
279.92	243.41	311.24	270.64
293.79	255.48	326.65	284.05
306.41	266.44	340.68	296.24
319.00	277.40	354.69	308.43
331.62	288.37	368.71	320.62
344.23	299.34	382.74	332.82
356.85	310.30	396.75	345.00
368.19	320.16	409.38	355.98
379.54	330.03	421.98	366.94
390.89	339.91	434.61	377.92
402.23	349.77	447.22	388.89
413.58	359.63	459.85	399.87
422.41	367.31	469.65	408.39
431.24	374.99	479.47	416.92
440.07	382.67	489.28	425.46
448.88	390.34	499.09	433.99
457.72	398.01	508.91	442.53
461.50	401.30	513.12	446.19
465.28	404.59	517.33	449.85
469.06	407.88	521.53	453.50
472.85	411.17	525.73	457.16
476.64	414.46	529.94	460.82

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025. Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 4 (ZIP Codes 690-693)

Age	Plan A**		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	342.24	297.60								
65	228.16	198.40	286.13	248.81	207.12	180.11	158.54	137.87	148.59	129.21
66	228.16	198.40	286.13	248.81	207.12	180.11	158.54	137.87	148.59	129.21
67	228.16	198.40	286.13	248.81	207.12	180.11	158.54	137.87	148.59	129.21
68	240.70	209.31	301.86	262.49	218.51	190.01	167.26	145.45	156.77	136.32
69	253.25	220.22	317.61	276.18	229.91	199.92	175.98	153.03	164.94	143.43
70	265.81	231.14	333.34	289.86	241.29	209.82	184.70	160.61	173.11	150.53
71	277.21	241.05	347.65	302.31	251.66	218.83	192.63	167.51	180.55	157.00
72	288.62	250.97	361.95	314.74	262.02	227.84	200.55	174.39	187.97	163.45
73	300.03	260.89	376.26	327.18	272.36	236.84	208.49	181.29	195.40	169.91
74	311.44	270.82	390.57	339.62	282.72	245.85	216.41	188.18	202.84	176.38
75	322.84	280.73	404.87	352.07	293.07	254.85	224.34	195.08	210.26	182.84
76	333.11	289.66	417.75	363.26	302.39	262.95	231.48	201.29	216.95	188.65
77	343.38	298.59	430.62	374.45	311.72	271.06	238.61	207.49	223.64	194.47
78	353.64	307.51	443.50	385.65	321.04	279.16	245.75	213.70	230.32	200.28
79	363.92	316.45	456.37	396.85	330.36	287.27	252.87	219.89	237.01	206.09
80	374.18	325.37	469.25	408.04	339.68	295.38	260.01	226.10	243.70	211.91
81	382.16	332.31	479.27	416.76	346.93	301.68	265.57	230.93	248.90	216.44
82	390.14	339.26	489.28	425.46	354.18	307.99	271.11	235.75	254.09	220.95
83	398.14	346.21	499.30	434.18	361.43	314.29	276.66	240.58	259.30	225.48
84	406.12	353.15	509.31	442.88	368.67	320.59	282.20	245.40	264.50	230.00
85	414.10	360.09	519.32	451.58	375.93	326.90	287.76	250.23	269.70	234.52
86	417.53	363.07	523.62	455.32	379.03	329.60	290.14	252.29	271.93	236.46
87	420.95	366.04	527.91	459.05	382.14	332.29	292.52	254.36	274.16	238.40
88	424.38	369.02	532.21	462.79	385.25	335.00	294.90	256.43	276.38	240.33
89	427.79	371.99	536.49	466.52	388.36	337.70	297.27	258.50	278.62	242.28
90+	431.22	374.98	540.78	470.24	391.46	340.40	299.65	260.57	280.84	244.21

Age	Plan C		Plan F	
	Male	Female	Male	Female
0-64				
65	265.58	230.94	295.28	256.77
66	265.58	230.94	295.28	256.77
67	265.58	230.94	295.28	256.77
68	280.19	243.64	311.52	270.89
69	294.79	256.34	327.76	285.01
70	309.40	269.04	344.00	299.13
71	322.68	280.59	358.77	311.98
72	335.95	292.13	373.53	324.81
73	349.23	303.68	388.30	337.65
74	362.52	315.23	403.06	350.49
75	375.80	326.78	417.82	363.32
76	387.74	337.17	431.11	374.88
77	399.69	347.56	444.40	386.43
78	411.65	357.96	457.69	397.99
79	423.59	368.34	470.97	409.54
80	435.55	378.74	484.27	421.10
81	444.84	386.82	494.59	430.08
82	454.14	394.91	504.93	439.07
83	463.44	402.99	515.26	448.06
84	472.72	411.06	525.60	457.04
85	482.02	419.15	535.94	466.03
86	486.01	422.61	540.37	469.89
87	489.99	426.08	544.80	473.74
88	493.98	429.54	549.22	477.58
89	497.96	433.01	553.65	481.44
90+	501.95	436.47	558.08	485.29

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025.
Premium payment may be made monthly.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

MONTHLY PREMIUMS | PREFERRED – Non-Tobacco User

AREA 4 (ZIP Codes 690-693) – Household Discount Applied*

Age	Plan A**		Plan B		Plan G		Plan L		Plan N		Plan C		Plan F	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	290.91	252.96												
65	193.94	168.64	243.21	211.49	176.05	153.09	134.76	117.19	126.30	109.83	225.74	196.30	250.99	218.25
66	193.94	168.64	243.21	211.49	176.05	153.09	134.76	117.19	126.30	109.83	225.74	196.30	250.99	218.25
67	193.94	168.64	243.21	211.49	176.05	153.09	134.76	117.19	126.30	109.83	225.74	196.30	250.99	218.25
68	204.59	177.91	256.58	223.12	185.73	161.51	142.17	123.63	133.25	115.87	238.16	207.09	264.79	230.26
69	215.26	187.19	269.97	234.75	195.42	169.93	149.58	130.08	140.20	121.92	250.57	217.89	278.60	242.26
70	225.94	196.47	283.34	246.38	205.10	178.35	156.99	136.52	147.14	127.95	262.99	228.68	292.40	254.26
71	235.63	204.89	295.50	256.96	213.91	186.01	163.74	142.38	153.47	133.45	274.28	238.50	304.95	265.18
72	245.33	213.32	307.66	267.53	222.72	193.66	170.47	148.23	159.77	138.93	285.56	248.31	317.50	276.09
73	255.03	221.76	319.82	278.10	231.51	201.31	177.22	154.10	166.09	144.42	296.85	258.13	330.05	287.00
74	264.72	230.20	331.98	288.68	240.31	208.97	183.95	159.95	172.41	149.92	308.14	267.95	342.60	297.92
75	274.41	238.62	344.14	299.26	249.11	216.62	190.69	165.82	178.72	155.41	319.43	277.76	355.15	308.82
76	283.14	246.21	355.09	308.77	257.03	223.51	196.76	171.10	184.41	160.35	329.58	286.59	366.44	318.65
77	291.87	253.80	366.03	318.28	264.96	230.40	202.82	176.37	190.09	165.30	339.74	295.43	377.74	328.47
78	300.59	261.38	376.97	327.80	272.88	237.29	208.89	181.64	195.77	170.24	349.90	304.27	389.04	338.29
79	309.33	268.98	387.91	337.32	280.81	244.18	214.94	186.91	201.46	175.18	360.05	313.09	400.32	348.11
80	318.05	276.56	398.86	346.83	288.73	251.07	221.01	192.18	207.14	180.12	370.22	321.93	411.63	357.93
81	324.84	282.46	407.38	354.25	294.89	256.43	225.73	196.29	211.56	183.97	378.11	328.80	420.40	365.57
82	331.62	288.37	415.89	361.64	301.05	261.79	230.44	200.39	215.98	187.81	386.02	335.67	429.19	373.21
83	338.42	294.28	424.40	369.05	307.22	267.15	235.16	204.49	220.40	191.66	393.92	342.54	437.97	380.85
84	345.20	300.18	432.91	376.45	313.37	272.50	239.87	208.59	224.82	195.50	401.81	349.40	446.76	388.48
85	351.98	306.08	441.42	383.84	319.54	277.86	244.60	212.70	229.24	199.34	409.72	356.28	455.55	396.13
86	354.90	308.61	445.08	387.02	322.18	280.16	246.62	214.45	231.14	200.99	413.11	359.22	459.31	399.41
87	357.81	311.13	448.72	390.19	324.82	282.45	248.64	216.21	233.04	202.64	416.49	362.17	463.08	402.68
88	360.72	313.67	452.38	393.37	327.46	284.75	250.66	217.97	234.92	204.28	419.88	365.11	466.84	405.94
89	363.62	316.19	456.02	396.54	330.11	287.04	252.68	219.72	236.83	205.94	423.27	368.06	470.60	409.22
90+	366.54	318.73	459.66	399.70	332.74	289.34	254.70	221.48	238.71	207.58	426.66	371.00	474.37	412.50

Plan C and Plan F: Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025. Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 4 (ZIP Codes 690-693)

Age	Plan A**		Plan B		Plan G		Plan L		Plan N		Plan C		Plan F	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	393.57	342.24												
65	262.38	228.16	329.05	286.13	238.19	207.12	182.33	158.54	170.88	148.59	305.41	265.58	339.57	295.28
66	262.38	228.16	329.05	286.13	238.19	207.12	182.33	158.54	170.88	148.59	305.41	265.58	339.57	295.28
67	262.38	228.16	329.05	286.13	238.19	207.12	182.33	158.54	170.88	148.59	305.41	265.58	339.57	295.28
68	276.81	240.70	347.14	301.86	251.29	218.51	192.35	167.26	180.29	156.77	322.22	280.19	358.25	311.52
69	291.24	253.25	365.25	317.61	264.39	229.91	202.38	175.98	189.69	164.94	339.01	294.79	376.93	327.76
70	305.68	265.81	383.34	333.34	277.49	241.29	212.40	184.70	199.07	173.11	355.81	309.40	395.61	344.00
71	318.79	277.21	399.80	347.65	289.40	251.66	221.53	192.63	207.63	180.55	371.08	322.68	412.59	358.77
72	331.91	288.62	416.24	361.95	301.32	262.02	230.64	200.55	216.17	187.97	386.34	335.95	429.56	373.53
73	345.03	300.03	432.70	376.26	313.22	272.36	239.76	208.49	224.71	195.40	401.62	349.23	446.54	388.30
74	358.15	311.44	449.15	390.57	325.13	282.72	248.87	216.41	233.26	202.84	416.89	362.52	463.52	403.06
75	371.26	322.84	465.61	404.87	337.03	293.07	257.99	224.34	241.80	210.26	432.17	375.80	480.49	417.82
76	383.08	333.11	480.41	417.75	347.75	302.39	266.20	231.48	249.49	216.95	445.90	387.74	495.78	431.11
77	394.88	343.38	495.21	430.62	358.47	311.72	274.41	238.61	257.19	223.64	459.65	399.69	511.06	444.40
78	406.69	353.64	510.03	443.50	369.19	321.04	282.61	245.75	264.87	230.32	473.40	411.65	526.34	457.69
79	418.50	363.92	524.83	456.37	379.91	330.36	290.81	252.87	272.56	237.01	487.13	423.59	541.62	470.97
80	430.31	374.18	539.63	469.25	390.63	339.68	299.01	260.01	280.25	243.70	500.88	435.55	556.91	484.27
81	439.49	382.16	551.16	479.27	398.97	346.93	305.40	265.57	286.24	248.90	511.57	444.84	568.78	494.59
82	448.66	390.14	562.67	489.28	407.31	354.18	311.77	271.11	292.21	254.09	522.26	454.14	580.67	504.93
83	457.86	398.14	574.20	499.30	415.64	361.43	318.16	276.66	298.19	259.30	532.95	463.44	592.55	515.26
84	467.04	406.12	585.71	509.31	423.97	368.67	324.54	282.20	304.18	264.50	543.63	472.72	604.44	525.60
85	476.22	414.10	597.22	519.32	432.32	375.93	330.92	287.76	310.15	269.70	554.33	482.02	616.33	535.94
86	480.16	417.53	602.16	523.62	435.89	379.03	333.66	290.14	312.72	271.93	558.91	486.01	621.42	540.37
87	484.09	420.95	607.09	527.91	439.46	382.14	336.39	292.52	315.29	274.16	563.49	489.99	626.52	544.80
88	488.03	424.38	612.04	532.21	443.04	385.25	339.13	294.90	317.84	276.38	568.07	493.98	631.60	549.22
89	491.96	427.79	616.97	536.49	446.61	388.36	341.87	297.27	320.41	278.62	572.66	497.96	636.70	553.65
90+	495.91	431.22	621.90	540.78	450.18	391.46	344.60	299.65	322.97	280.84	577.24	501.95	641.79	558.08

Plan C and Plan F: Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025.
Premium payment may be made monthly.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

MONTHLY PREMIUMS | STANDARD – Tobacco User

AREA 4 (ZIP Codes 690-693) – Household Discount Applied*

Age	Plan A**		Plan B		Plan G		Plan L		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-64	334.53	290.91								
65	223.02	193.94	279.69	243.21	202.46	176.05	154.98	134.76	145.25	126.30
66	223.02	193.94	279.69	243.21	202.46	176.05	154.98	134.76	145.25	126.30
67	223.02	193.94	279.69	243.21	202.46	176.05	154.98	134.76	145.25	126.30
68	235.29	204.59	295.07	256.58	213.60	185.73	163.50	142.17	153.25	133.25
69	247.55	215.26	310.46	269.97	224.73	195.42	172.02	149.58	161.24	140.20
70	259.83	225.94	325.84	283.34	235.87	205.10	180.54	156.99	169.21	147.14
71	270.97	235.63	339.83	295.50	245.99	213.91	188.30	163.74	176.49	153.47
72	282.12	245.33	353.80	307.66	256.12	222.72	196.04	170.47	183.74	159.77
73	293.28	255.03	367.79	319.82	266.24	231.51	203.80	177.22	191.00	166.09
74	304.43	264.72	381.78	331.98	276.36	240.31	211.54	183.95	198.27	172.41
75	315.57	274.41	395.77	344.14	286.48	249.11	219.29	190.69	205.53	178.72
76	325.62	283.14	408.35	355.09	295.59	257.03	226.27	196.76	212.07	184.41
77	335.65	291.87	420.93	366.03	304.70	264.96	233.25	202.82	218.61	190.09
78	345.69	300.59	433.53	376.97	313.81	272.88	240.22	208.89	225.14	195.77
79	355.72	309.33	446.11	387.91	322.92	280.81	247.19	214.94	231.68	201.46
80	365.76	318.05	458.69	398.86	332.04	288.73	254.16	221.01	238.21	207.14
81	373.57	324.84	468.49	407.38	339.12	294.89	259.59	225.73	243.30	211.56
82	381.36	331.62	478.27	415.89	346.21	301.05	265.00	230.44	248.38	215.98
83	389.18	338.42	488.07	424.40	353.29	307.22	270.44	235.16	253.46	220.40
84	396.98	345.20	497.85	432.91	360.37	313.37	275.86	239.87	258.55	224.82
85	404.79	351.98	507.64	441.42	367.47	319.54	281.28	244.60	263.63	229.24
86	408.14	354.90	511.84	445.08	370.51	322.18	283.61	246.62	265.81	231.14
87	411.48	357.81	516.03	448.72	373.54	324.82	285.93	248.64	268.00	233.04
88	414.83	360.72	520.23	452.38	376.58	327.46	288.26	250.66	270.16	234.92
89	418.17	363.62	524.42	456.02	379.62	330.11	290.59	252.68	272.35	236.83
90+	421.52	366.54	528.61	459.66	382.65	332.74	292.91	254.70	274.52	238.71

Plan C		Plan F	
Male	Female	Male	Female
259.60	225.74	288.63	250.99
259.60	225.74	288.63	250.99
259.60	225.74	288.63	250.99
273.89	238.16	304.51	264.79
288.16	250.57	320.39	278.60
302.44	262.99	336.27	292.40
315.42	274.28	350.70	304.95
328.39	285.56	365.13	317.50
341.38	296.85	379.56	330.05
354.36	308.14	393.99	342.60
367.34	319.43	408.42	355.15
379.01	329.58	421.41	366.44
390.70	339.74	434.40	377.74
402.39	349.90	447.39	389.04
414.06	360.05	460.38	400.32
425.75	370.22	473.37	411.63
434.83	378.11	483.46	420.40
443.92	386.02	493.57	429.19
453.01	393.92	503.67	437.97
462.09	401.81	513.77	446.76
471.18	409.72	523.88	455.55
475.07	413.11	528.21	459.31
478.97	416.49	532.54	463.08
482.86	419.88	536.86	466.84
486.76	423.27	541.19	470.60
490.65	426.66	545.52	474.37

Only available to those Medicare eligible prior to Jan. 1, 2020

Rates valid through March 31, 2026. Premium is based on your gender and age as of April 1, 2025.
Premium payment may be made monthly.

*See page 20 for information regarding household premium discount.

**Plan A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

Important Information

Premium Information

Blue Cross and Blue Shield of Nebraska can only raise your premium if we raise the premium for all policies like yours in this state. Your premium may change each year as you age, and that change will be made on the annual renewal date, and the rate will be calculated using your attained age as of the renewal date. If you move your permanent residence, it may result in a premium change.

Your contract is guaranteed renewable. It cannot be canceled because of the number of claims you file or the amount of benefits you collect. It should be expected that your premiums will increase whenever Medicare deductibles or coinsurance provisions change, or when higher medical costs increase.

Household Premium Discount

You are eligible for a household premium discount if you currently have a person residing in your home (but no more than three people, age 60 or older), who is: a) your legal spouse; or b) a person at least 18 years of age with whom you have resided continuously for the last 12 months. The discount on the premium will be 15%. The policy's household premium discount will be removed if the other adult no longer resides with you (other than in the case of his or her death).

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 Blue Cross and Blue Shield of Nebraska.

Right To Return Policy

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

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-0001

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

These policies may not fully cover all of your medical costs.

Neither Blue Cross and Blue Shield of Nebraska 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 the "Medicare and You" handbook for more details.

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. Blue Cross and Blue Shield of Nebraska 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.

PLAN A | 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 A PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, miscellaneous services and supplies.			
First 60 days	All but $1,736	$0	$1,736 (Part A deductible)
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - 365 additional days - Beyond the additional 365 days	 All but $868 a day $0 $0	 $868 a day 100% of Medicare-eligible expenses $0	 $0 $0 ** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three 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 $217 a day	$0	Up to $217 a day
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN A | Medicare (Part B)

Medical Services – Per Calendar Year

* Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT **Expenses include physician's services; inpatient and outpatient medical and surgical services and supplies; physical, occupational and speech therapy; and diagnostic tests and durable medical equipment.**			
First $283 of Medicare-approved amounts*	$0	$0	$283 (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 three pints	$0	All costs	$0
Next $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES			
	100%	$0	$0
PARTS A AND B **HOME HEALTH CARE – MEDICARE-APPROVED SERVICES**			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN B | 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 B PAYS	YOU PAY
HOSPITALIZATION* **Semiprivate room and board, general nursing, miscellaneous services and supplies.**			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - 365 additional days - Beyond the additional 365 days	 All but $868 a day $0 $0	 $868 a day 100% of Medicare-eligible expenses $0	 $0 $0 ** All costs
SKILLED NURSING FACILITY CARE* **You must meet Medicare's requirements, including having been in a hospital for at least three 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 $217 a day	$0	Up to $217 a day
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE **You must meet Medicare's requirements, including a doctor's certification of terminal illness.**			
	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN B | Medicare (Part B)

Medical Services – Per Calendar Year

* Once you have been billed $283 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 B PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT **Expenses include physician's services; inpatient and outpatient medical and surgical services and supplies; physical, occupational and speech therapy; and diagnostic tests and durable medical equipment.**			
First $283 of Medicare-approved amounts*	$0	$0	$283 (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 three pints	$0	All costs	$0
Next $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES			
	100%	$0	$0
PARTS A AND B **HOME HEALTH CARE – MEDICARE-APPROVED SERVICES**			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN G | Medicare (Part A)

Hospital Services – Per Benefit Period

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

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOSPITALIZATION* **Semiprivate room and board, general nursing, miscellaneous services and supplies.**			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - 365 additional days - Beyond the additional 365 days	 All but $868 a day $0 $0	 $868 a day 100% of Medicare-eligible expenses $0	 $0 $0 ** All costs
SKILLED NURSING FACILITY CARE* **You must meet Medicare's requirements, including having been in a hospital for at least three 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 $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE **You must meet Medicare's requirements, including a doctor's certification of terminal illness.**			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN G | Medicare (Part B)

Medical Services – Per Calendar Year

* Once you have been billed $283 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 **Expenses include physician's services; inpatient and outpatient medical and surgical services and supplies; physical, occupational and speech therapy; and diagnostic tests and durable medical equipment.**			
First $283 of Medicare-approved amounts*	$0	$0	$283 (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 three pints	$0	All costs	$0
Next $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES			
	100%	$0	$0
PARTS A AND B **HOME HEALTH CARE – MEDICARE-APPROVED SERVICES**			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits – Not Covered By Medicare

SERVICES	MEDICARE PAYS	PLAN G 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 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

PLAN N | Medicare (Part A)

Hospital Services – Per Benefit Period

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

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOSPITALIZATION* **Semiprivate room and board, general nursing, miscellaneous services and supplies.**			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - 365 additional days - Beyond the additional 365 days	 All but $868 a day $0 $0	 $868 a day 100% of Medicare-eligible expenses $0	 $0 $0** All costs
SKILLED NURSING FACILITY CARE* **You must meet Medicare's requirements, including having been in a hospital for at least three 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 $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE **You must meet Medicare's requirements, including a doctor's certification of terminal illness.**			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN N | Medicare (Part B)

Medical Services – Per Calendar Year

* Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT **Expenses include physician's services; inpatient and outpatient medical and surgical services and supplies; physical, occupational and speech therapy; and diagnostic tests and durable medical equipment.**			
First $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than $20 per office visit and $50 per emergency room visit copayment amount**	Up to $20 per office visit and up to $50 per emergency room visit**
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First three pints	$0	All costs	$0
Next $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES			
	100%	$0	$0
PARTS A AND B **HOME HEALTH CARE – MEDICARE-APPROVED SERVICES**			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

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 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

**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.

PLAN L

Medicare (Part A)

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $3,610 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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 L PAYS	YOU PAY
HOSPITALIZATION ** **Semiprivate room and board, general nursing, miscellaneous services and supplies.**			
First 60 days	All but $1,736	$1,302 (75% of Part A deductible)	$434 (25% of Part A deductible) ◆
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - 365 additional days - Beyond the additional 365 days	 All but $868 a day $0 $0	 $868 a day 100% of Medicare-eligible expenses $0	 $0 $0 *** All costs
SKILLED NURSING FACILITY CARE ** **You must meet Medicare's requirements, including having been in a hospital for at least three 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 $217 a day	Up to $162.75 a day	Up to $54.25 a day ◆
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	75%	25% ◆
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	75% of copayment/coinsurance	25% of copayment/ coinsurance ◆

*** **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 L | Medicare (Part B)

Medical Services – Per Calendar Year

**** Once you have been billed $283 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 L PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT **Expenses include physician's services; inpatient and outpatient medical and surgical services and supplies; physical, occupational and speech therapy; and diagnostic tests and durable medical equipment.**			
First $283 of Medicare-approved amounts ****	$0	$0	$283 (Part B deductible) **** ◆
Preventive Benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ◆
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $4,000) *
BLOOD			
First three pints	$0	75%	25% ◆
Next $283 of Medicare-approved amounts ****	$0	$0	$283 (Part B deductible) ◆
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5% ◆
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES			
	100%	$0	$0
PARTS A AND B **HOME HEALTH CARE – MEDICARE-APPROVED SERVICES**			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $283 of Medicare-approved amounts *****	$0	$0	$283 (Part B deductible) ◆
Remainder of Medicare-approved amounts	80%	15%	5% ◆

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts to $4,000 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

***** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

PLAN C | Medicare (Part A)

Hospital Services – Per Benefit Period

Only available for individuals who were Medicare eligible before Jan. 1, 2020.

* 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 C PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, miscellaneous services and supplies.			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - 365 additional days - Beyond the additional 365 days	 All but $868 a day $0 $0	 $868 a day 100% of Medicare-eligible expenses $0	 $0 $0 ** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three 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 $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN C | Medicare (Part B)

Medical Services – Per Calendar Year | **Only available for individuals who were Medicare eligible before Jan. 1, 2020.**

* Once you have been billed $283 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 C PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT **Expenses include physician's services; inpatient and outpatient medical and surgical services and supplies; physical, occupational and speech therapy; and diagnostic tests and durable medical equipment.**			
First $283 of Medicare-approved amounts*	$0	$283	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First three pints	$0	All costs	$0
Next $283 of Medicare-approved amounts*	$0	$283	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES			
	100%	$0	$0
PARTS A AND B **HOME HEALTH CARE – MEDICARE-APPROVED SERVICES**			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $283 of Medicare-approved amounts*	$0	$283	$0
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits – Not Covered By Medicare

SERVICES	MEDICARE PAYS	PLAN C 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 Unites 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

PLAN F | Medicare (Part A)

Hospital Services – Per Benefit Period

Only available for individuals who were Medicare eligible before Jan. 1, 2020.

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

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION* **Semiprivate room and board, general nursing, miscellaneous services and supplies.**			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - 365 additional days - Beyond the additional 365 days	 All but $868 a day $0 $0	 $868 a day 100% of Medicare-eligible expenses $0	 $0 $0 ** All costs
SKILLED NURSING FACILITY CARE* **You must meet Medicare's requirements, including having been in a hospital for at least three 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 $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE **You must meet Medicare's requirements, including a doctor's certification of terminal illness.**			
	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN F | Medicare (Part B)

Medical Services – Per Calendar Year | **Only available for individuals who were Medicare eligible before Jan. 1, 2020.**

* Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT **Expenses include physician's services; inpatient and outpatient medical and surgical services and supplies; physical, occupational and speech therapy; and diagnostic tests and durable medical equipment.**			
First $283 of Medicare-approved amounts*	$0	$283 (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 three pints	$0	All costs	$0
Next $283 of Medicare-approved amounts*	$0	$283 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES			
	100%	$0	$0
PARTS A AND B **HOME HEALTH CARE – MEDICARE-APPROVED SERVICES**			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment: First $283 of Medicare-approved amounts*	$0	$283 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

Other Benefits – Not Covered By Medicare

SERVICES	MEDICARE PAYS	PLAN F 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 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

Scope of Sales Appointment Confirmation Form

The Centers for Medicare and Medicaid Services (CMS) requires agents to document the scope of a marketing appointment at least 48 hours prior to any face-to-face sales meeting to ensure understanding of what will be discussed between the agent and the Medicare beneficiary (or his/her authorized representative). All information provided on this form is confidential and should be completed by each person with Medicare or his/her authorized representative. **Refer to page 2 for product type descriptions.**

Agents must be licensed, contracted and certified, where applicable, to sell each of the plans listed below:

Please INITIAL BELOW in the box beside the type of product(s) you want the agent to discuss:

	Medicare Prescription Drug Plan (PDP)		Ancillary Products
	Medicare Advantage Plan(s)		Medicare Supplement (Medigap) Products

Beneficiary or Authorized Representative

By signing this form, you agree to a meeting with a sales agent to discuss the types of products you initialed above. Please note, the person who will discuss the products is either employed or contracted by a Medicare Plan. They do not work directly for the federal government. This individual may also be paid based on your enrollment in a plan.
Signing this form does NOT obligate you to enroll in a plan, affect your current or future enrollment nor will it automatically enroll you in a Medicare plan or any plans discussed.

Beneficiary or authorized representative signature and signature date:

Beneficiary Printed Name **Beneficiary Date of Birth (Optional)**

Beneficiary Signature **Date**

If you are the ***authorized representative***, please sign above and print your name and relationship to the beneficiary

Agent Signature____________________ **Date**____________

To be completed by Agent:

Agent Name	**Agent Phone**
Beneficiary Address	Beneficiary Phone
Initial Method of Contact (indicate if beneficiary walked in) Required	
Date Appointment Completed Required	Plans the agent represented during this meeting

Medicare Plan Descriptions

Stand-Alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP): A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service plans and Medicare Medical Savings Account Plans.

Medicare Advantage Plans (Part C)

A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage.

Preferred Provider Organization (PPO): Require you to use doctors and hospitals in the plan's provider network in order to get the most out of your benefits. Referrals are not needed to see a doctor, specialist or out-of-network provider; however, you will likely have to pay more out of pocket.

Health Maintenance Organization (HMO): HMO plans have a network of doctors and hospitals. Many HMO plans are now open access, where you do not have a primary care physician requirement and may not require a referral to see a specialist. In most HMOs, you can only get care from doctors or hospitals that are in the network (except in emergencies).

Dental/Vision Products

Health Insurance plans offering additional benefits4 for consumers who are looking to cover needs for dental or other ancillary products. These plans are not affiliated or connected to Medicare.

Medicare Supplement (Medigap) Products

Health insurance plans offering a supplemental policy to fill “gaps” in Original Medicare coverage. A Medigap policy typically pays some or all of the deductible and coinsurance amounts applicable to Medicare-covered services and sometimes covers items and services that are not covered by Medicare, such as care outside of the country. These plans are not affiliated or connected to Medicare.

Agents are required to submit a Scope of Appointment form with each Medicare Advantage Plan or Medicare Prescription Drug enrollment application. Scope of Appointment documentation is subject to CMS record retention requirements.

Out-of-network/non-contracted providers are under no obligation to treat Blue Cross and Blue Shield of Nebraska Medicare Advantage members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Rev. 06/10/2023

Y0139_24SOAForm_C FVNR 0623
50-187 (08-28-23)

Blue Cross and Blue Shield of Nebraska is an independent licensee
of the Blue Cross and Blue Shield Association.

Individual Enrollment Department
PO Box 3248
Omaha, NE 68180-0001

Medicare Supplement Application

Section I. Subscriber Information

Last Name	First Name	MI	Social Security Number	Date of Birth (MM/DD/YYYY)	☐ M ☐ F

Physical Address (Street, PO Box)	City	State	ZIP

If you wish to receive mailed correspondence at a different address than listed above, please indicate your mailing address below.

Mailing Address (Street, PO Box)	City	State	ZIP

Cell Phone #	Home Phone	Email

Have you used tobacco in any form during the past 12 months? (The use of tobacco products means any use of cigarettes, pipes, cigars, vapes or any other tobacco products regardless of the number of times or frequency of use).

☐ Yes ☐ No

Household Premium Discount

You may be eligible for a lower premium rate based on your answer to the following question:
Do you currently have a person residing in your home, who is:

a) Your legal spouse; or
b) A person 18 years of age or older with whom you have continuously resided for the last 12 months.

☐ Yes ☐ No

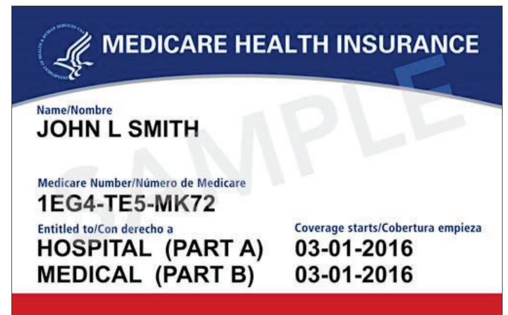
Section II. Medicare Information

Please reference your red, white and blue Medicare card to complete this section.

Your Medicare number: ____________________

Hospital (Part A) Coverage Start Date: ________________

Medical (Part B) Coverage Start Date: ________________



Section III. Plan Selection

Please select the Blue Cross and Blue Shield of Nebraska (BCBSNE) Medicare Supplement policy you are applying for:

☐ Plan B ☐ Plan G ☐ Plan L ☐ Plan N

☐ Plan A* ☐ Plan C** ☐ Plan F**

*Plan A is available to individuals who are Medicare eligible due to disability and under the age of 65 excluding end stage renal disease

**Plan C and F are only available to individuals who were Medicare eligible prior to Jan. 1, 2020

Blue Cross and Blue Shield of Nebraska is an independent licensee of the Blue Cross Blue Shield Association

Section IV. Option Dental and Vision Plan Selection

These plans are separate from the Medicare Supplement plan, and are not required for issuance of a Medicare Supplement.

The BlueDental plan is an Individual policy offered by BCBSNE. If a dental plan is elected at the same time (initial enrollment) as an approved, issued Medicare Supplement, the waiting period for Coverage B is waived. Waiting periods may apply based on the policy selected. Benefit details including waiting period information is available at nebraskablue.com.

Please select the BCBSNE dental policy you are applying for.

- ☐ BlueDental 750 plan
  $100 Deductible
  $750 Annual Benefit Maximum
- ☐ BlueDental 1200 plan
  $100 Deductible
  $1,200 Annual Benefit Maximum
- ☐ BlueDental 1500 plan
  $50 Deductible
  $1,500 Annual Benefit Maximum

The BlueVision plan is an Individual policy offered by BCBSNE.
Please select the BCBSNE vision policy you are applying for.

- ☐ Individual Vision 130
  $130 frame/contact lens allowance
  $10 lens copay
- ☐ Individual Vision 150
  $150 frame/contact lens allowance
  $10 lens copay
- ☐ Individual Vision 200
  $200 frame/contact lens allowance
  $10 lens copay

Section V. Medicare Questions

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guarantee issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. **Please include a copy of the notice from your prior insurer with your application. Please answer all questions. Check Yes or No below.**

TO THE BEST OF YOUR KNOWLEDGE:

Yes	No	Question
☐ Yes	☐ No	**1.** (a) Did you turn age 65 in the last 6 months? Will you turn age 65 in the next 90 days?
☐ Yes	☐ No	(b) Did you enroll in Medicare Part B in the last 6 months?
		(c) If yes, what is the effective date? ______ / _____/ _____
☐ Yes	☐ No	**2.** (a) Are you covered for medical assistance through the state Medicaid program? Note to applicant: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer No to this question.
☐ Yes	☐ No	(b) If yes, will Medicaid pay your premiums for this Medicare Supplement policy?
☐ Yes	☐ No	(c) If yes, do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?
		3. (a) If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO plan), fill in your start and end dates below. If you are still covered under this plan, leave "End" blank. Start _____ / _____ / _____ End _____ / _____ / _____
☐ Yes	☐ No	(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this Medicare Supplement policy?
☐ Yes	☐ No	(c) Was this your first time in this type of Medicare plan?
☐ Yes	☐ No	(d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan?
☐ Yes	☐ No	**4.** (a) Do you have another Medicare Supplement policy in force?
		(b) If so, with what company, and what plan do you have? ______________________
		(c) I understand if approved, my new policy will replace the current policy in effect. If my application is not approved, my existing coverage will remain in effect with no change.
☐ Yes	☐ No	**5.** (a) Have you had coverage under any other health insurance within the past 63 days? (for example, an employer, union or individual plan)?
		(b) If so, with what company and what kind of policy? ______________________
		(c) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "End" blank. Start _____ / _____ / _____ End _____ / _____ / _____
☐ Yes	☐ No	(d) Is this loss of coverage due to retirement (applicant or applicant's spouse) or involuntary loss of coverage?

Section VI. Health Information Questions

If you qualify for this coverage during Open Enrollment or a Guarantee Issue period, you are not required to answer questions in Section 6. If your answer is yes to any of the questions in section 6.1, you are not eligible for coverage.

Height: _______ feet _______ inches Weight: ________ pounds

PLEASE ANSWER ALL OF THE FOLLOWING HEALTH QUESTIONS BELOW:

Section 6.1

☐ Yes	☐ No	**1.** Are you currently confined to a wheelchair or another motorized device?
☐ Yes	☐ No	**2.** Are you currently hospitalized, confined to a bed or in a nursing home?
☐ Yes	☐ No	**3.** Have you ever been diagnosed as having or received treatment by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) and/or positive HIV and/or AIDS Related Complex (ARC)?
☐ Yes	☐ No	**4.** Have you ever had an organ or stem cell transplant or been advised to have an organ or stem cell transplant (excluding cornea implants)?
		5. Within the past two(2) years, have you had, been treated for, taken medication for or been advised by a medical professional that you have any of the following :
☐ Yes	☐ No	(a) Internal cancer, leukemia or melanoma (even if the condition is in remission)
☐ Yes	☐ No	(b) Coronary artery disease, heart attack, cardiac angioplasty, stent placement or bypass surgery
☐ Yes	☐ No	(c) Congestive heart failure, cardiomyopathy (heart muscle disease), cardiomegaly (enlarged heart), atrial fibrillation or other heart rhythm disorder, peripheral vascular disease, carotid artery disease, unoperated valvular heart disease, unoperated aneurysm or implanted pacemaker/ICD (implanted cardiac defibrillator)
☐ Yes	☐ No	(d) Stroke or transient ischemic attack (TIA)
☐ Yes	☐ No	(e) Chronic Kidney Disease (Stages 3, 4, or 5), kidney failure or kidney disease requiring dialysis
☐ Yes	☐ No	(f) Diabetes a. Taking more than 50 units of insulin daily b. Taking three or more medications (oral or injections) to control blood sugar c. With complications including retinopathy, neuropathy, kidney disease, skin ulcers, high blood pressure, poor circulation, peripheral artery disease or peripheral thrombotic disease
☐ Yes	☐ No	(g) Cirrhosis, chronic hepatitis or liver disease
☐ Yes	☐ No	(h) Degenerative disc disease, amputations caused by disease, osteoporosis with related fractures, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, or arthritis that restricts mobility or activities of daily living
☐ Yes	☐ No	(i) Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or any Chronic Pulmonary Disorder or Cardiac Disorder requiring oxygen
☐ Yes	☐ No	(j) Systemic Lupus, Scleroderma, or Myasthenia Gravis
☐ Yes	☐ No	(k) Alcoholism or Drug Abuse
☐ Yes	☐ No	(l) Alzheimer's Disease, Dementia, or other cognitive disorder
☐ Yes	☐ No	(m) Parkinson's disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease), Huntington's disease, or Cerebral Palsy
☐ Yes	☐ No	**6.** Have you had a seizure in the last 12 months?
☐ Yes	☐ No	**7.** Have you been hospitalized inpatient three or more times within the past two (2) years?

Section VI. Health Information Questions (continued)

If your answer is yes to any of the questions in Section 6.2, you may not be eligible for coverage and are subject to an underwriting review. If you would like consideration to be given to an application that contains a "yes" answer to any questions in this section, please attach/upload an explanation stating how long the condition has existed, how it is/was being controlled and the recommended treatment.

Section 6.2

☐ Yes	☐ No	**1.** Have you been advised by a medical professional to have surgery, medical tests, treatment, or therapy that has not been performed or do you have any pending test results?
☐ Yes	☐ No	**2.** Have you been hospitalized for complications arising from SARS-CoV-2 (Coronavirus) or the COVID-19 disease? (a) Dates of hospitalization: a. Admission Date ____________________ b. Discharge Date ____________________
☐ Yes	☐ No	(b) Were you placed on a ventilator?

Section VII. Medication Information

Are you currently taking, or have you taken any prescription or over-the-counter medications within the past 12 months?
If yes, please list the medication(s) and condition(s) being treated below. Attach a separate sheet if necessary.

Medication Name (copy from pharmacy label): ____________________

Date originally prescribed: ____________________

Dosage and frequency: ____________________

Diagnosis/condition being treated: ____________________

Medication Name (copy from pharmacy label): ____________________

Date originally prescribed: ____________________

Dosage and frequency: ____________________

Diagnosis/condition being treated: ____________________

Medication Name (copy from pharmacy label): ____________________

Date originally prescribed: ____________________

Dosage and frequency: ____________________

Diagnosis/condition being treated: ____________________

Medication Name (copy from pharmacy label): ____________________

Date originally prescribed: ____________________

Dosage and frequency: ____________________

Diagnosis/condition being treated: ____________________

Medication Name (copy from pharmacy label): ____________________

Date originally prescribed: ____________________

Dosage and frequency: ____________________

Diagnosis/condition being treated: ____________________

Section VIII. Payment Options

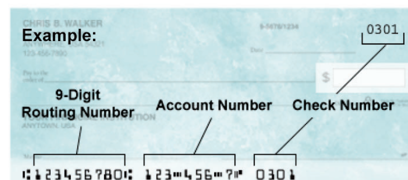
☐ Monthly paper bill ☐ Monthly automatic bank withdrawal (Even if you have existing coverage, please complete the section below and **attach a voided check** to avoid processing delays.)

I authorize Blue Cross and Blue Shield of Nebraska to make automatic withdrawals from the account shown below (or on the attached voided check), and the Financial Institution named below to charge the stated account for payment of my premium. The initial authorization will be charged on or after the 20th of each month. Such amount may be changed from time to time by Blue Cross and Blue Shield of Nebraska, giving me written notice before charging the account. This authorization is to remain in effect until Blue Cross and Blue Shield of Nebraska has received written notification from me of a termination date.

Name of Bank: ______________________ Town/City: ________________ Type of Account: ☐ Checking ☐ Savings

Account Number: ______________________________

Routing/ABA Number: ☐☐☐☐☐☐☐☐☐



Name of Payor as shown on bank account: ______________________

Please note: Payor must also sign below in the signature section of the application if different from applicant.

For additional payment options, register for [an online member account at myNebraskaBlue.com](https://myNebraskaBlue.com) after receiving your member ID card. Registering allows you to set up recurring payments, make one-time payments and see billing statements and history.

BCBSNE prohibits and will not accept premium and cost-sharing payments for BCBSNE members from third party payers with the exception of members' family members, legal personal representatives or conservators, court-appointed representatives or any other parties unless required by law.

Section IX. Applicant Statements

I acknowledge receipt of the following documents at the time I completed this application:

☐ Outline of Coverage ☐ Pamphlet "Guide to Health Insurance for People with Medicare"

By providing your telephone numbers you agree that we, along with our affiliates and/or vendors, may call or text any phone numbers you give us, including a wireless number, using an automatic telephone dialing system and/ or a prerecorded message. Without limit these calls may be about treatment options, other health-related benefits and services, enrollment, payment, or billing.

Coverage will be effective the first of the month following approval. If you wish to request a different effective date, you may do so here: ________________.

If an effective date is requested and approved, I understand I cannot request a change of that date, and that premiums are owed from that date forward.

I hereby authorize any physician, hospital, pharmacy, pharmacy benefit manager, health insurance plan, health information exchange, health data utility company, consumer reporting agency, or any other entity that possesses any diagnosis, treatment, prescription, and medical information about me to furnish such information to Blue Cross and Blue Shield of Nebraska and its agents for the purposes of processing claims or for underwriting or administrative purposes. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV/AIDS, sexually transmitted diseases and/or genetic information, unless otherwise restricted by state or federal law. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. I authorize any party, including the Medicare program and its contractors, to release eligibility, claims, payment, or medical information to Blue Cross and Blue Shield of Nebraska for the same purposes. This authorization shall be valid for ninety (90) days unless a shorter period is required by applicable law and may be revoked by sending written notice to Blue Cross and Blue Shield of Nebraska, 1919 Aksarben Drive, Omaha, NE 68180. Your revocation will not apply to any information that was previously obtained in reliance on your authorization. Your failure to execute this authorization may result in the party identified above being unable to complete the stated purpose. I understand I will receive a copy of this authorization. I understand that any false statements on this application may cause the coverage to be void.

Signature of Applicant: ______________________________ Date: ______________

Printed name of Applicant ______________________________ Date: ______________

______________________________ Date: ______________
Signature of payor as shown on bank account if payor is someone other than applicant

Blue Cross and Blue Shield of Nebraska is an independent licensee of the Blue Cross Blue Shield Association

AGENT SECTION ONLY

Agent shall list any other health insurance policies they have sold to the applicant:

List policies sold that are still in force. ______________________________

List policies sold in the past five (5) years which are no longer in force. ______________________________

☐ Replacement form (section 9) completed   Date: ______________ Agent Number: ______________

Signature of Agent: ______________________________

Section X. Information to Consider

1. You do not need more than one Medicare Supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan.

6. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

7. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

8. If you are enrolled under a Medicare Advantage plan, you are not eligible for a Medicare Supplement policy in addition to that plan.

9. Blue Cross and Blue Shield of Nebraska reserves the right to accept or decline this application for Medicare Supplement in whole or in part except when application is made during the initial six month open enrollment period beginning with the first month in which you are first enrolled under Medicare Part B and you are 65 years of age or older. No right is created by this application including any advance premium payment and the application shall not be considered accepted unless the contract is actually issued to you. Should you discontinue Medicare Part B Medical Insurance Benefits, it shall be your responsibility to notify Blue Cross and Blue Shield of Nebraska of the change.

Section X. Notice to applicant regarding replacement of Medicare Supplement insurance or Medicare Advantage

Save this Notice! It may be important to you in the future.**

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Blue Cross and Blue Shield of Nebraska. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. ** This notice will be returned to you after processing your application.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Agent:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

☐ Additional benefits.

☐ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

____

____

☐ Other. (please specify)

____

____

If you still wish to terminate your current policy and replace it with new coverage, be certain to answer all questions truthfully and completely on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your current policy until you have received your new policy and are sure that you want to keep it.

______________________________ ______________

Signature of Agent, Broker or Other Representative | Agent Number

____

Typed Name and Address of Agent, Broker or Other Representative

______________________________ ______________

Relationship to Applicant (if Representative) | Date

______________________________ ______________

Applicant's Signature | Date

This page is intentionally left blank.

Non-discrimination and Translation Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Nebraska (BCBSNE) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSNE does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.
BCBSNE:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at 800-991-5840, TTY 711 between 7:30 a.m. to 6 p.m., Central time, Monday through Friday.

If you believe that Blue Cross and Blue Shield of Nebraska 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:

Manager, Corporate Compliance
Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-001
800-991-5840, TTY: 711
CivilRights@NebraskaBlue.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Manager of Corporate Compliance 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 ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf.
For quick processing, use the OCR online portal to file a complaint.

ATTENTION: This notice may have important information about your application or coverage. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or get help with costs. If you or someone you're helping has questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-991-5840. This notice is translated as federally required.

Arabic

تنبيه: قد يتضمن هذا الإشعار معلومات مهمة عن تطبيقك أو تأمينك. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد يلزمك اتخاذ إجراء قبل المواعيد النهائية المحددة للحفاظ على التأمين الصحي أو للحصول على مساعدة بشأن التكاليف. إذا كنت أنت أو أحد من تساعدهم لديكم أسئلة، فلك الحق في الحصول على مساعدة ومعلومات بلغتك وبدون تكلفة. للتحدث مع أحد المترجمين الفوريين، اتصل برقم 1-800-991-5840

Chinese Traditional

注意：本通知可能含有與您的申請或保險有關的重要資訊。在本通知中尋找重要的日期。您可能需要在某個截止日期前採取行動，以保持您的健康保險或獲得費用方面的幫助。如果您或者您正幫助的人有疑問，您有權利以您的語言免費獲得提供的幫助與資訊。致電口譯員，請撥打1-800-991-5840。

German

Achtung: Diese Mitteilung kann wichtige Informationen über Ihren Antrag oder die Versicherungsdeckung beinhalten. Beachten Sie wichtige Fristen in dieser Mitteilung. Sie müssen unter Umständen Maßnahmen innerhalb bestimmter Fristen ergreifen, um Ihren Krankenversicherungsschutz zu erhalten oder eine Kostenerstattung zu erhalten. Wenn Sie oder jemand, dem Sie helfen, Fragen hat, können Sie kostenlos Hilfe und Informationen in Ihrer Sprache erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte 1-800-991-5840 an.

50-101-1 (03-20-25)

Spanish (Mexico)

ATENCIÓN: Este aviso puede contener información importante sobre su solicitud o cobertura. Ponga atención a las fechas clave en este aviso. Puede ser que usted necesite realizar algunas acciones para determinadas fechas y así mantener su cobertura de salud o para obtener ayuda con los costos. Si usted o alguien a quien usted ayuda tiene alguna pregunta, tiene el derecho de recibir información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-800-991-5840.

Farsi

توجه این اعلامیه ممکن است اطلاعات مهمی درباره درخواست یا طرح پوشش بیمه‌تان داشته باشد. تاریخ های اصلی را در این اعلامیه جستجو کنید. ممکن است لازم باشد تا موعد مقرری اقدام کنید تا پوشش بیمه درمانیتان حفظ شود یا هزینه های درمانی را دریافت کنید. اگر شما یا فردی دیگر که به او کمک می کنید، سؤالی دارید، از این حق برخوردار هستید تا راهنمایی و اطلاعات را به صورت رایگان به زبان خودتان دریافت کنید. برای صحبت کردن با یک مترجم، با شماره 1-800-991-5840 تماس بگیرید.

French (Europe)

ATTENTION : Cet avis peut contenir des informations importantes concernant votre demande ou votre garantie. Prêtez attention aux dates clés indiquées. Il vous faudra peut-être prendre des mesures avant une certaine date pour pouvoir conserver votre assurance santé ou bénéficier d'aides au paiement. Si vous ou une personne que vous aidez avez des questions, vous pouvez obtenir gratuitement de l'assistance et des informations dans votre langue. Pour parler à un interprète, appelez le 1-800-991-5840.

Japanese

ご注意：本通知書には、患者さんの申請や保険について重大な情報が含まれている可能性があります。本通知書の日付をご覧ください。医療保険を利用したり、費用についてサポートを受けるには、本通知書に従って特定の期限までに手続きしてください。患者さん、または付き添いの方が質問がある場合は、母国語で無料で支援を受けたり、情報を受け取る権利があります。通訳と話したい場合は、1-800-991-5840. まで電話をおかけください。

Karen

ဟ်သူဉ်ဟ်သး–တၢ်ဘိးဘဉ်သ့ဉ်ညါအံၤ ဘဉ်သ့ဉ်သ့ဉ် ကအိဉ်ဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢ အရှ့ဒိဉ်ဘဉ်ယး နလံာ်ပတံထီဉ်တၢ် မ့တမ့ၢ် တၢ်အုဉ်ကီၤသးန့ဉ်လီၤ.
ကွၢ်ယှ မုၢ်နံၤမုၢ်သီအရှ့ဒိဉ်လၢ လံာ်ဘိးဘဉ်သ့ဉ်ညါအံၤအပူၤတက့ၢ်.
ဘဉ်သ့ဉ်သ့ဉ် နကဘဉ် ဟံးဂ့ၢ်ဝီလၢ မုၢ်နံၤလၢခံကတၢၢ်လၢ တၢ်ဟ်ပနီဉ်န့ၢ်နၤ လၢနကဟ့ဉ်နတၢ်အိဉ်ဆူဉ်အိဉ်ချ့ တၢ်ဘူးတၢ်လဲတဖဉ် မ့တမ့ၢ် မၤန့ၢ်တၢ်မၤစၢၤလၢ တၢ်ပ္ၤလီၤလဲတဖဉ်န့ဉ်လီၤ.
နၤ မ့တမ့ၢ် ပှၤတဂၤဂၤလၢ နမၤစၢၤမ့ၢ်အိဉ်ဒီးတၢ်သံကွၢ်အယိ, နအိဉ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢ ကမၤန့ၢ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢ နကျိာ်လၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤဘဉ်န့ဉ်လီၤ.
လၢနကကတိၤတၢ်ဒီး ပှၤကျိးထံတၢ်အဂီၢ်, ကိး1-800-991-5840.တက့ၢ်.

Korean

주의: 본고지에는해당신청서또는적용범위에대한중요한정보가있을수있습니다.
본고지의주요날짜를찾으십시오.해당건강보험을유지하거나비용을지원받는특정기한까지조치를취하셔야합니다.본인자신이나본인이돕고있는누군가가질문이있다면무료로모국어로된도움과정보를얻을수있는권리가있습니다.통역사와통화하려면1-800-991-5840. 번으로전화하십시오.

Kurdish

ئاگاداری

ڕەنگە ئەم ئاگاداریە زانیاری گرنگی تێدا بێت دەربارەی داواکاری یان ڕووماڵکردنەکەت.بەدوای بەرواره سەرەکیەکانی ناو ئەم ئاگاداریە بگەڕێ.لەوانەیە پێویست بکات لە هەندێک دوا وادە کردارێک بکەیت بۆ ئەوەی ڕووماڵی تەندروستیت بەردەوام بێت یان یارمەتی بۆ تێچووەکانت دەست بخەیت.ئەگەر تۆ یان کەسێک کە تۆ یارمەتی دەدەیت پرسیاری هەیە، تۆ مافی دەسکەوتنی یارمەتی و زانیاریت بە زمانی خۆت بێ بەرامبەر هەیە.بۆ قسەکردن لەگەڵ وەرگێڕێک، پەیوەندی بە 18009915840. بکە.

Lao

ສິ່ງທີ່ຄວນເອົາໃຈໃສ່: ແຈ້ງການສະບັບນີ້ ອາດຈະມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບການສະໝັກ ຫຼື ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ.
ຈົ່ງຊອກຫາວັນທີທີ່ສໍາຄັນໃນແຈ້ງການສະບັບນີ້. ທ່ານອາດຈະຕ້ອງດໍາເນີນການໃນຂອບເຂດເວລາໃດໜຶ່ງ
ເພື່ອຮັກສາການຄຸ້ມຄອງດ້ານສຸຂະພາບຂອງທ່ານ ຫຼື ໄດ້ຮັບການຊ່ວຍເຫຼືອທາງດ້ານງົບປະມານ. ຖ້າຫາກທ່ານ ຫຼືບຸກຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອຢູ່ນັ້ນ
ມີຄໍາຖາມ,ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ໄດ້ຮັບຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕ້ອງການລົມກັບນາຍແປພາສາ,
ຈົ່ງໂທຫາເບີ 1-800-991-5840.

Nepali

ध्यानाकर्षण: यो सूचनामा तपाईंको निवेदन वा कभरेजको बारेमा महत्त्वपूर्ण जानकारी हुनसक्छ। यो सूचनामा मुख्य मितिहरू हेर्नुहोस्। तपाईंको स्वास्थ्य कभरेज वा लागतमा मद्दत प्राप्त गर्न तपाईंले निश्चित समयसीमा भित्र कारबाही लिनुपर्ने हुनसक्छ। तपाईं वा तपाईंले सहायता गरेका कसैसँग जिज्ञासाहरू छन् भने तपाईंसँग आफ्नो भाषामा नि:शुल्क सहायता र जानकारी प्राप्त गर्ने अधिकार छ। दोभाषेसँग कुरा गर्न
1-800-991-5840.मा कल गर्नुहोस्।

Oromo

HUBAACHIISA: Beeksisi kun odeeffannoo barbaachisaa waa'ee iyyata keetii yookaan waa'ee tajaajiloota qabaachuu mala. Beeksisa kana irraa guyyoota barbaachisoo ta'an ilaali. Tajaajila fayyaa kee itti fufsiisuuf guyyoota murtaa'an irratti tarkaanfiin ati fudhattu yookaan kaffaltiidhaan gargaarsi ati argattu jiraachu mala. Yoo ati ykn namni ati gargaartu, gaaffii qabaattan, gatii malee gargaarsaa fi oddeeffanno afaan dandeessaaniin argachuun mirga keessaani. Warra afaan hikkaaniif lakkoofsa kanaan bilbilaa 1-800-991-5840.

Russian

ВНИМАНИЕ! В данном уведомлении может содержаться важная информация о вашей заявке или страховке. В нем также указаны ключевые даты. Вам может потребоваться выполнить некоторые действия к определенному сроку для сохранения вашей медицинской страховки или получения помощи в оплате расходов. Если у вас или у человека, которому вы помогаете, возникнут вопросы, вы имеете право получить помощь и информацию на своем языке бесплатно. Чтобы поговорить с переводчиком, позвоните по номеру 1-800-991-5840.

Vietnamese

CHÚ Ý: Thông báo này có thể chứa thông tin quan trọng về đơn đăng ký hoặc bảo hiểm của quý vị. Tìm những ngày chính trong thông báo này. Quý vị có thể cần hành động trước một số thời hạn để duy trì bảo hiểm sức khỏe của mình hoặc được giúp đỡ có tính phí. Nếu quý vị hoặc người quý vị đang giúp đỡ, có thắc mắc, quý vị có quyền lấy thông tin và được trợ giúp bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi số 1-800-991-5840.

NOTES

P.O. Box 3248 • Omaha, NE 68180-0001

Blue Cross and Blue Shield of Nebraska is an independent licensee of the Blue Cross Blue Shield Association. Blue Cross and Blue Shield of Nebraska is not connected with or endorsed by the United States government or the federal Medicare program.

9175-JAN-508 (12-18-25)