

2018 Horizon Blue Cross Blue Shield of New Jersey

Medicare Supplement Plan Comparisons



Horizon Contemporary Medigap Plans



HorizonBlue.com/Medicare

2018 Benefits Snapshot.

HORIZON CONTEMPORARY MEDIGAP PLANS	Plan C Pays	Plan F Pays	Plan G Pays	Plan K Pays	Plan N Pays
Part A — Hospital Care¹ \$1,340 first 60 days deductible for each benefit period	✓	✓	✓	✓ 50% of the cost	✓
Charges for the first three pints of blood	✓	✓	✓	✓ 50% of the cost	✓
\$335 per day for 61st–90th day in the hospital	✓	✓	✓	✓	✓
\$670 per day for 91st–150th day in the hospital ²	✓	✓	✓	✓	✓
100% of bills after day 150 in the hospital for an additional 365 days	✓	✓	✓	✓	✓
Skilled Nursing Facility Care \$167.50 per day for 21st–100th day of a skilled nursing facility stay	✓	✓	✓	✓ 50% of the cost	✓
Part B — Physicians' Services and Supplies \$183 Part B deductible	✓	✓			
Generally, 20% of the Medicare-approved amounts (Part B coinsurance) and 20% of Medicare-approved charges for Durable Medical Equipment (after \$183 Part B deductible is met)	✓	✓	✓	✓ 50% of the cost	✓ other than up to \$20 per office visit, up to \$50 per ER visit
Charges for the first three pints of blood	✓	✓	✓	✓	✓
100% of Medicare Part B excess charges (up to Medicare's limit)		✓	✓		
Additional expenses not covered by Medicare Emergency care in a foreign country³ 100% of Medicare Part B excess charges (up to Medicare's limit)	✓	✓	✓		✓
Annual Maximum Out of Pocket Benefits for medically necessary care received in a foreign country	N/A	N/A	N/A	✓ 100% after the \$5,240 MOOP limit is reached ⁴	N/A

TYPE OF CONTRACT	PLAN NAME	AGE GROUP	MONTHLY PREMIUM
SINGLE	HORIZON CONTEMPORARY MEDIGAP PLAN A	Age 65-69	\$146.47
		Age 70-74	\$190.46
		Age 75-79	\$222.97
		Age 80+	\$236.59
	HORIZON CONTEMPORARY MEDIGAP PLAN C	Age 65-69	\$240.21
		Age 70-74	\$312.37
		Age 75-79	\$365.63
		Age 80+	\$388.01
	HORIZON CONTEMPORARY MEDIGAP PLAN F	Age 65-69	\$204.18
		Age 70-74	\$265.54
		Age 75-79	\$310.85
		Age 80+	\$329.83
	HORIZON CONTEMPORARY MEDIGAP PLAN G	Age 65-69	\$193.25
		Age 70-74	\$245.41
		Age 75-79	\$283.82
		Age 80+	\$299.99
	HORIZON CONTEMPORARY MEDIGAP PLAN K	Age 65-69	\$103.15
		Age 70-74	\$131.01
		Age 75-79	\$151.52
		Age 80+	\$160.16
HORIZON CONTEMPORARY MEDIGAP PLAN N	Age 65-69	\$124.45	
	Age 70-74	\$158.01	
	Age 75-79	\$182.78	
	Age 80+	\$193.18	

BENEFIT CHART OF MEDICARE SUPPLEMENT BENEFIT PLANS

Medicare supplement insurance can only be sold in ten standard plans. This chart shows the benefits included in each plan. Every company must make available Plan A. Horizon Blue Cross Blue Shield of New Jersey also offers Plans C, F, G, K and N.

Orange: Offered by Horizon BCBSNJ.

Gray: Not offered.

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

Basic benefits:

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

G	K	L	M	N
Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance except up to \$20 copayment for office visit and up to \$50 copayment for ER
Skilled Nursing Facility coinsurance	50% Skilled Nursing Facility coinsurance	50% Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
Part B Excess (100%)				
Foreign Travel Emergency				Foreign Travel Emergency
	Out-of-pocket limit \$5,240; paid at 100% after limit reached	Out-of-pocket limit \$2,620; paid at 100% after limit reached		

HORIZON CONTEMPORARY MEDIGAP PLAN A 2018 BENEFIT SUMMARY

Medicare (Part A) • Hospital Services • Per Benefit Period

Service	Medicare Pays	Plan Pays	You Pay
Hospitalization¹			
Semi-private room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$1,340	\$0	\$1,340 (Part A \$0 deductible)
61st thru 90th day	All but \$335 a day	\$335 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$670 a day	\$670 a day	\$0
• Once lifetime reserve days are used:		100% of Medicare-eligible expenses	\$0 ²
- Additional 365 days	\$0		
- Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$167.50 a day	\$0	Up to \$167.50 per day
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

Medicare (Part B) • Medical Services • Per Calendar Year

Service	Medicare Pays	Plan Pays	You Pay
Medical Expenses			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$183 of Medicare-approved amounts ³	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
Above Medicare-approved amounts	\$0	\$0	All costs
Blood			
First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare-approved amounts ³	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	20%	\$0
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
Parts A & B			
Home Health Care			
MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			\$183 (Part B deductible)
• First \$183 of Medicare-approved amounts ³	\$0	\$0	
• Remainder Medicare-approved amounts	80%	20%	\$0

HORIZON CONTEMPORARY MEDIGAP PLAN C 2018 BENEFIT SUMMARY

Medicare (Part A) • Hospital Services • Per Benefit Period

Service	Medicare Pays	Plan Pays	You Pay
Hospitalization¹			
Semi-private room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$1,340	\$1,340 (Part A \$0 deductible)	\$0
61st thru 90th day	All but \$335 a day	\$335 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$670 a day	\$670 a day	\$0
• Once lifetime reserve days are used:		100% of Medicare-eligible expenses	\$0 ²
- Additional 365 days	\$0		
- Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$167.50 a day	All but \$167.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

Medicare (Part B) • Medical Services • Per Calendar Year

Service	Medicare Pays	Plan Pays	You Pay
Medical Expenses			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$183 of Medicare-approved amounts ³	\$0	\$183 (Part B deductible)	\$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 3 pints	\$0	All costs	\$0
Next \$183 of Medicare-approved amounts ³	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
Parts A & B			
Home Health Care			
MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
• First \$183 of Medicare-approved amounts ³	\$0	\$183 (Part B deductible)	\$0
• Remainder Medicare-approved amounts	80%	20%	\$0
Other Benefits Not Covered by Medicare			
Foreign Travel Not Covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

HORIZON CONTEMPORARY MEDIGAP PLAN F 2018 BENEFIT SUMMARY

Medicare (Part A) • Hospital Services • Per Benefit Period

Service	Medicare Pays	Plan Pays	You Pay
Hospitalization¹			
Semi-private room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$1,340	\$1,340 (Part A \$0 deductible)	\$0
61st thru 90th day	All but \$335 a day	\$335 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$670 a day	\$670 a day	\$0
• Once lifetime reserve days are used:		100% of Medicare-eligible expenses	\$0 ²
- Additional 365 days	\$0		
- Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$167.50 a day	All but \$167.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

Medicare (Part B) • Medical Services • Per Calendar Year

Service	Medicare Pays	Plan Pays	You Pay
Medical Expenses			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$183 of Medicare-approved amounts ³	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
Above Medicare-approved amounts			
	\$0	All costs	\$0
Blood			
First 3 pints			
	\$0	All costs	\$0
Next \$183 of Medicare-approved amounts ³	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES			
	100%	\$0	\$0
Parts A & B			
Home Health Care			
MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
• First \$183 of Medicare-approved amounts ³	\$0	\$183 (Part B deductible)	\$0
• Remainder Medicare-approved amounts	80%	20%	\$0
Other Benefits Not Covered by Medicare			
Foreign Travel Not Covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

HORIZON CONTEMPORARY MEDIGAP PLAN G 2018 BENEFIT SUMMARY

Medicare (Part A) • Hospital Services • Per Benefit Period

Service	Medicare Pays	Plan Pays	You Pay
Hospitalization¹			
Semi-private room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$1,340	\$1,340 (Part A \$0 deductible)	\$0
61st thru 90th day	All but \$335 a day	\$335 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$670 a day	\$670 a day	\$0
• Once lifetime reserve days are used:		100% of Medicare-eligible expenses	\$0 ²
- Additional 365 days	\$0		
- Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$167.50 a day	All but \$167.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

Medicare (Part B) • Medical Services • Per Calendar Year

Service	Medicare Pays	Plan Pays	You Pay
Medical Expenses			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$183 of Medicare-approved amounts ³	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
Above Medicare-approved amounts	\$0	100%	\$0
Blood			
First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare-approved amounts ³	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
Parts A & B			
Home Health Care			
MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
• First \$183 of Medicare-approved amounts ³	\$0	\$0	\$183 (Part B deductible)
• Remainder Medicare-approved amounts	80%	20%	\$0
Other Benefits Not Covered by Medicare			
Foreign Travel Not Covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

HORIZON CONTEMPORARY MEDIGAP PLAN K 2018 BENEFIT SUMMARY

Medicare (Part A) • Hospital Services • Per Benefit Period

Service	Medicare Pays	Plan Pays	You Pay
Hospitalization¹			
Semi-private room and board, general nursing and miscellaneous services and supplies. First 60 days	All but \$1,340	\$670 (50% of Part A deductible)	\$670 (50% of Part A deductible)
61st thru 90th day	All but \$335 a day	\$335 a day	\$0
91st day and after: • While using 60 lifetime reserve days	All but \$670 a day	\$670 a day	\$0
• Once lifetime reserve days are used: - Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0 ²
- Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$167.50 a day	Up to \$83.75 a day	Up to \$83.75 a day
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	50%	50%
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	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance

Medicare (Part B) • Medical Services • Per Calendar Year

Service	Medicare Pays	Plan Pays	You Pay
Medical Expenses			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$183 of Medicare-approved amounts ³	\$0	\$0	\$183 (Part B deductible)
Preventative 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 10%	Generally 10%
Part B Excess Charges			
Above Medicare-approved amounts	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$5,240) ⁴
Blood			
First 3 pints	\$0	50%	50%
Next \$183 of Medicare-approved amounts ³	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%
Clinical Laboratory Services			
TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
Parts A & B			
Home Health Care			
MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
• First \$183 of Medicare-approved amounts ³	\$0	\$0	\$183 (Part B deductible)
• Remainder Medicare-approved amounts	80%	10%	10%

HORIZON CONTEMPORARY MEDIGAP PLAN N 2018 BENEFIT SUMMARY

Medicare (Part A) • Hospital Services • Per Benefit Period

Service	Medicare Pays	Plan Pays	You Pay
Hospitalization¹			
Semi-private room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$1,340	\$1,340 (Part A deductible)	\$0
61st thru 90th day	All but \$335 a day	\$335 a day	\$0
91st day and after:			
• While using 60 lifetime reserve days	All but \$670 a day	\$670 a day	\$0
• Once lifetime reserve days are used:		100% of Medicare-eligible expenses	\$0 ²
- Additional 365 days	\$0		
- Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$167.50 a day	All but \$167.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			
	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

Medicare (Part B) • Medical Services • Per Calendar Year

Service	Medicare Pays	Plan Pays	You Pay
Medical Expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$183 of Medicare-approved amounts ³	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital, and the emergency visit is covered as a Medicare Part A expense.	Up to \$20 per office per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital, and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges Above Medicare-approved amounts	\$0	\$0	All costs
Blood First 3 pints	\$0	100%	\$0
Next \$183 of Medicare-approved amounts ³	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(Continued)

Medicare (Part B) • Medical Services • Per Calendar Year

Parts A & B

Home Health Care

MEDICARE-APPROVED SERVICES

Medically necessary skilled-care services and medical supplies

100% \$0 \$0

Durable medical equipment

- First \$183 of Medicare-approved amounts³

\$0 \$0 \$183 (Part B deductible)

- Remainder Medicare-approved amounts

80% 20% \$0

Other Benefits Not Covered by Medicare

Foreign Travel Not Covered by Medicare

Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA.

First \$250 each calendar year

\$0 \$0 \$250

Remainder of charges

\$0 80% to a lifetime maximum benefit of \$50,000 20% and amounts over the \$50,000 lifetime maximum

Important Notes

All deductibles and coinsurance are 2018 amounts.

1. 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.

2. 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.

3. Once you have been billed \$183 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

4. You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$5,240 each calendar year. 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. This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$5,240 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.

If you have any questions about our Horizon Contemporary Medigap Plans, please call us at **1-888-328-4542**.