2020

Smart Solutions Brochure

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Service category	Keystone 65 Basic Rx HMO*	
	Philadelphia and Bucks	Chester, Delaware, Montgomery
Medical with Rx	**$0**	**$0**
...and Choice Program	**$12.00**	**$12.00**
...and Choice Plus Program	**$25.00**	**$25.00**
Monthly plan premium		
Primary Care Physician (PCP) Visits	$0 preferred PCP copay $15 standard PCP copay	
Specialist Visits	$45 copay; no referrals required	
Emergency Care (Covered worldwide)	$90 copay; separate copay from inpatient stay (not waived if admitted)	
Urgent Care (Covered worldwide)**	$15 copay for retail clinic; $40 copay in-network urgent care center	
Routine Chiropractic and Podiatry Services §	$20 copay for Chiropractic visit (up to 6 visits per year); $25 copay for Podiatry visit (up to 6 visits per year)	
Ambulatory Surgical Center (ASC)/ Outpatient Hospital	$200 copay Ambulatory Surgical Center per visit $350 copay Outpatient Hospital Facility per visit	
Inpatient Hospital	$250/day for days 1–7; $1,750 maximum per admission; no copay for additional days per admission; unlimited days per admission	
Fitness Program	SilverSneakers®	
Over-the-Counter (OTC) items[1]	$30 quarterly (four times per year) allowance during the benefit year for OTC items purchased through Convey	
Comprehensive Dental Care Routine Vision Care Routine Hearing Services	Available only with the Choice ($12) and Choice Plus ($25) Program options; see page 7 for details	
Prescription drugs		
Preferred Retail and Mail Order 90-day supply for 2 months' copay	$4/Preferred Generic; $20/Generic	
Preferred Retail Cost-Sharing†	Preferred Generic $2/Generic $10/Preferred Brand $47/Non-Preferred drug $100/33% coinsurance specialty drug	
Standard Retail Cost-Sharing†	Preferred Generic $9/Generic $20/Preferred Brand $47/Non-Preferred drug $100/33% coinsurance specialty drug	
Initial Coverage Limit	A maximum of $4,020 in total drug cost	
Coverage Gap	You pay 25% of generic drug costs and 25% of brand-name drug costs until you reach a maximum of $6,350	
Catastrophic	You pay the greater of $3.60 generic and $8.95 brand or 5% coinsurance after reaching a maximum of $6,350 catastrophic trigger	

[1]Quarterly OTC allowance does not carry over. Check your Evidence of Coverage for more details.
Keystone 65 Basic Rx HMO and Keystone 65 Focus Rx HMO-POS each have a $6,700 out-of-pocket maximum for 2020. Keystone 65 Select Rx HMO has a $5,500 out-of-pocket maximum. The maximum out-of-pocket is the amount that you will have to pay for care during the year. This does not include your premium, just out-of-pocket costs, such as copays and coinsurance.

*All Keystone 65 Basic Rx HMO and Keystone 65 Select HMO members must use in-network hospitals and physicians with the exception of emergencies or urgently needed care.

§Routine visits are in addition to Medicare-covered services.

Keystone 65 Focus Rx HMO-POS‡

	Philadelphia and Bucks	Chester, Delaware, Montgomery
Medical with Rx	**$9.00**	**$19.00**
...and Choice Program	**$21.00**	**$31.00**
...and Choice Plus Program	**$34.00**	**$44.00**

$0 preferred PCP copay
$10 standard PCP copay

$40 copay; no referrals required

$90 copay; separate copay from inpatient stay (not waived if admitted)

$10 copay for retail clinic;
$40 copay in-network urgent care center

$20 copay for Chiropractic visit (up to 6 visits per year);
$25 copay for Podiatry visit (up to 6 visits per year)

$200 copay Ambulatory Surgical Center per visit
$350 copay Outpatient Hospital Facility per visit

$210/day for days 1–6; $1,260 maximum per admission; no copay for additional days per admission; unlimited days per admission

SilverSneakers®

$30 quarterly (four times per year) allowance during the benefit year for OTC items purchased through Convey

Available only with the Choice ($12) and Choice Plus ($25) Program options; see page 7 for details

$4/Preferred Generic; $20/Generic

Preferred Generic $2/Generic $10/Preferred Brand
$47/Non-Preferred drug $100/33% coinsurance specialty drug

Preferred Generic $9/Generic $20/Preferred Brand
$47/Non-Preferred drug $100/33% coinsurance specialty drug

A maximum of $4,020 in total drug cost

You pay 25% of generic drug costs and 25% of brand-name drug costs until you reach a maximum of $6,350

You pay the greater of $3.60 generic and $8.95 brand or 5% coinsurance after reaching a maximum of $6,350 catastrophic trigger

Keystone 65 Select HMO*

	Philadelphia and Bucks	Chester, Delaware, Montgomery
Medical only	**$34.50**	**$49.50**
...with Choice Program	**$46.50**	**$61.50**
...with Choice Plus Program	**$59.50**	**$74.50**
Medical with Rx	**$54.50**	**$80.50**
...and Choice Program	**$66.50**	**$92.50**
...and Choice Plus Program	**$79.50**	**$105.50**

$0 preferred PCP copay
$15 standard PCP copay

$40 copay; no referrals required

$90 copay; separate copay from inpatient stay (not waived if admitted)

$15 copay for retail clinic;
$40 copay in-network urgent care center

$20 copay for Chiropractic visit (up to 6 visits per year);
$20 copay for Podiatry visit (up to 6 visits per year)

$200 copay Ambulatory Surgical Center per visit
$350 copay Outpatient Hospital Facility per visit

$250/day for days 1–6; $1,500 maximum per admission; no copay for additional days per admission; unlimited days per admission

SilverSneakers®

$30 quarterly (four times per year) allowance during the benefit year for OTC items purchased through Convey

Available only with the Choice ($12) and Choice Plus ($25) Program options; see page 7 for details

$2/Preferred Generic; $18/Generic

Preferred Generic $1/Generic $9/Preferred Brand
$47/Non-Preferred drug $100/33% coinsurance specialty drug

Preferred Generic $9/Generic $20/Preferred Brand
$47/Non-Preferred drug $100/33% coinsurance specialty drug

A maximum of $4,020 in total drug cost

You pay 25% of generic drug costs and 25% of brand-name drug costs until you reach a maximum of $6,350

You pay the greater of $3.60 generic and $8.95 brand or 5% coinsurance after reaching a maximum of $6,350 catastrophic trigger

‡Keystone 65 Focus Rx HMO-POS has an annual plan level POS maximum limit of $1,000 per year. The POS benefit will apply to Medicare-covered medical (Parts A & B) benefits.
**For urgently needed care received outside the United States, the Emergency Room copayment will apply.
†For a complete directory of network pharmacies, visit www.ibxmedicare.com.

Service category	Keystone 65 Preferred HMO	
	Philadelphia and Bucks	Chester, Delaware, Montgomery
Monthly plan premium	**Medical only $178.00 Medical with Rx $228.00**	**Medical only $194.00 Medical with Rx $256.00**
Primary Care Physician (PCP) Visits	$0 preferred PCP copay $5 standard PCP copay	
Specialist Visits	$40 copay; no referrals needed	
Emergency Care (Covered worldwide)	$90 copay; separate copay from inpatient stay (not waived if admitted)	
Urgent Care (Covered worldwide)**	$5 copay for retail clinic; $40 copay for in-network urgent care center	
Routine Chiropractic Services and Podiatry Services ‡	$20 copay for Chiropractic visit (up to 6 visits per year); $20 copay for Podiatry visit (up to 6 visits per year)	
Ambulatory Surgical Center (ASC)/ Outpatient Hospital	$125 copay Ambulatory Surgical Center per visit $350 copay Outpatient Hospital Facility per visit	
Inpatient Hospital	$225/day for days 1–6; $1,350 maximum per admission; no copayment for additional days per admission; unlimited days per admission	
Fitness Program	SilverSneakers®	
Over-the-Counter (OTC) items[1]	$30 quarterly (four times per year) allowance during the benefit year for OTC items purchased through Convey	
Dental Care Routine Vision Care	$10 copay for routine dental; one exam and cleaning once every six months / one set bitewing x-rays per year; $10 copay for a routine eye exam and up to $200 allowance for glasses and lenses every year when purchased from Visionworks	
Routine Hearing Services	$10 copay for a routine hearing exam every year; Hearing aid benefit copay of $499 or $799 per hearing aid (one per ear/per year) provided through TruHearing	
Prescription drugs (optional)		
Preferred Retail and Mail Order 90-day supply for 2 months' copay	$2/Preferred Generic; $18/Generic	
Preferred Retail Cost-Sharing†	Preferred Generic $1/Generic $9/Preferred Brand $47/ Non-Preferred drug $100/33% coinsurance specialty drug	
Standard Retail Cost-Sharing†	Preferred Generic $9/Generic $20/Preferred Brand $47/ Non-Preferred drug $100/33% coinsurance specialty drug	
Initial Coverage Limit	A maximum of $4,020 in total drug cost	
Coverage Gap	You pay 25% of generic drug costs and 25% of brand-name drug costs until you reach a maximum of $6,350	
Catastrophic	You pay the greater of $3.60 generic and $8.95 brand or 5% coinsurance after reaching $6,350 catastrophic trigger	

[1]Quarterly OTC allowance does not carry over. Check your Evidence of Coverage for more details.
Keystone 65 Preferred HMO has a $4,000 out-of-pocket maximum for 2020. The maximum out-of-pocket is the amount that you will have to pay for care during the year. This does not include your premium, just out-of-pocket costs, such as copays and coinsurance.
All Keystone 65 Preferred HMO members must use in-network hospitals and physicians with the exception of emergent or urgently needed care, until your plan year renews.
‡ Routine visits are in addition to Medicare-covered services.

Service category	Personal Choice 65℠ Prime PPO*	
	Philadelphia and Bucks	Chester, Delaware, Montgomery
Monthly plan premium		
Medical with Rx	**$0**	**$0**
...and Choice	**$12.00**	**$12.00**
...and Choice Plus	**$25.00**	**$25.00**
Primary Care Physician (PCP) Visits	$5 preferred PCP copay; $20 standard PCP copay	
Specialist Visits	$40 preferred specialist copay; $50 standard specialist copay	
Emergency Care (Covered worldwide)	$90 copay; separate copay from inpatient stay (not waived if admitted)	
Urgent Care (Covered worldwide)**	$10 copay for retail clinic; $50 copay for urgent care center	
Routine Chiropractic and Podiatry Services‡	$20 copay for Chiropractic visit (up to 6 visits per year); $25 copay for Podiatry visit (up to 6 visits per year)	
Ambulatory Surgical Center (ASC)/ Outpatient Hospital	$250 copay Ambulatory Surgical Center per visit Preferred: $375 copay Outpatient Hospital Facility per visit Standard: $475 copay for Outpatient Hospital Facility per visit	
Inpatient Hospital	Preferred: $250/day for days 1–7; unlimited days per admission Standard: $310/day for days 1–7; unlimited days per admission	
Fitness Program	SilverSneakers®	
Over-the-Counter (OTC) items[1]	$30 quarterly (four times per year) allowance during the benefit year for OTC items purchased through Convey	
Comprehensive Dental Care Routine Vision Care Routine Hearing Services	Available only with Choice ($12) or Choice Plus ($25) Programs; see page 7 for details	
Prescription drugs		
Preferred Retail and Mail Order 90-day supply for 2 months' copay	$4/Preferred Generic; $20/Generic	
Preferred Retail Cost-Sharing†	Preferred Generic $2/Generic $10/Preferred Brand $47/Non-Preferred drug $100/33% coinsurance specialty drug	
Standard Retail Cost-Sharing†	Preferred Generic $9/Generic $20/Preferred Brand $47/Non-Preferred drug $100/33% coinsurance specialty drug	
Initial Coverage Limit	A maximum of $4,020 in total drug cost	
Coverage Gap	You pay 25% of generic drug costs and 25% of brand-name drug costs until you reach a maximum of $6,350	
Catastrophic	You pay the greater of $3.60 generic and $8.95 brand or 5% coinsurance after reaching $6,350 catastrophic trigger	

[1]Quarterly OTC allowance does not carry over. Check your Evidence of Coverage for more details.
Personal Choice 65 Prime PPO has an in-network out-of-pocket maximum of $6,700 and a combined in-network/ out-of-network out-of-pocket maximum of $10,000 for 2020.
Personal Choice 65 PPO has an in-network out-of-pocket maximum of $5,500 and a combined in-network/out-of-network out-of-pocket maximum of $10,000 for 2020. Personal Choice 65 Prime PPO has a $1,000 deductible for covered medical services received from out-of-network providers. *For out-of-network benefits, there is 30% coinsurance for most covered services. **For urgently needed care outside of the United States, the Emergency Room copayment will apply.
†For a complete directory of network pharmacies, visit www.ibxmedicare.com.
‡ Routine visits are in addition to Medicare-covered services.

Service category	Personal Choice 65SM PPO*	
	Philadelphia and Bucks	Chester, Delaware, Montgomery
Monthly plan premium		
Medical only	**$184.00**	**N/A**
...with Choice Program	**$196.00**	**N/A**
...with Choice Plus Program	**$209.00**	**N/A**
Medical with Rx	**$288.00**	**$159.00**
...and Choice Program	**$300.00**	**$171.00**
...with Choice Plus Program	**$313.00**	**$184.00**
Primary Care Physician (PCP) Visits	$5 PCP copay	
Specialist Visits	$40 copay; no referrals needed	
Emergency Care (Covered worldwide)	$90 copay; separate copay from inpatient stay (not waived if admitted)	
Urgent Care (Covered worldwide)**	$5 copay for retail clinic; $40 copay for urgent care center	
Routine Chiropractic and Podiatry Services§	$20 copay for Chiropractic visit (up to 6 visits per year); $20 copay for Podiatry visit (up to 6 visits per year)	
Ambulatory Surgical Center (ASC)/ Outpatient Hospital	$150 copay Ambulatory Surgical Center per visit $300 copay Outpatient Hospital Facility per visit	
Inpatient Hospital	$250/day for days 1–6; $1,500 maximum per admission ; no copayment for additional days per admission ; unlimited days per admission	
Fitness Program	SilverSneakers®	
Over-the-Counter (OTC) items[1]	$30 quarterly (four times per year) allowance during the benefit year for OTC items purchased through Convey	
Comprehensive Dental Care Routine Vision Care Routine Hearing Services	Available only with Choice ($12) or Choice Plus ($25) Programs; see page 7 for details	
Prescription drugs (optional)		
Preferred Retail and Mail Order 90-day supply for 2 months' copay	$2/Preferred Generic; $18/Generic	
Preferred Retail Cost-Sharing†	Preferred Generic $1/Generic $9/Preferred Brand $47/ Non-Preferred drug $100/33% coinsurance specialty drug	
Standard Retail Cost-Sharing†	Preferred Generic $9/Generic $20/Preferred Brand $47/ Non-Preferred drug $100/33% coinsurance specialty drug	
Initial Coverage Limit	A maximum of $4,020 in total drug cost	
Coverage Gap	You pay 25% of generic drug costs and 25% of brand-name drug costs until you reach a maximum of $6,350	
Catastrophic	You pay the greater of $3.60 generic and $8.95 brand or 5% coinsurance after reaching $6,350 catastrophic trigger	

[1]Quarterly OTC allowance does not carry over. Check your Evidence of Coverage for more details.
*For out-of-network benefits, there is 30% coinsurance for most covered services.
**For urgently needed care outside of the United States, the Emergency Room copayment will apply.
†For a complete directory of network pharmacies, visit www.ibxmedicare.com.
§ Routine visits are in addition to Medicare-covered services.

CHOICE AND CHOICE PLUS* PROGRAM OPTIONS

Service category	Choice	Choice Plus
Additional monthly plan premium	$12	$25
Routine Dental Care‡		
Provider Network	No Primary Dental Office (PDO) selection required**	No Primary Dental Office (PDO) selection required**
Routine exams/cleanings copay	$10; cleaning once every six months	$0; cleaning once every six months
Dental X-ray copay	$0; one set bitewing x-rays per year	$0; one set bitewing x-rays per year
Comprehensive Dental	50% coinsurance up to $500 allowance for comprehensive dental services like fillings, extractions, root canals, and crowns.	50% coinsurance up to $1,500 allowance for comprehensive dental services like fillings, extractions, dentures, partials, root canals, crowns, and some oral surgery.
Routine Vision Care‡		
Provider Network	Must use Davis Vision network provider	
Routine eye exam copay	$10; one routine eye exam every year	$10; one routine eye exam every year
Frames, lenses, and contact lenses *Eyewear doesn't include tints, progressives, transition lenses, polish, and insurance.*	Covered every year with first year coverage One (1) pair of eyeglass frames and lenses or one (1) pair of contact lenses. Includes: eyeglasses/frames from the Davis Vision Collection covered in full. $200 allowance for eyewear purchased from Visionworks; $150 allowance for all other eyewear purchased at a Davis Vision network provider $150 allowance for contact lenses purchased in lieu of frames and lenses.	Covered each year with first year coverage. One (1) pair of eyeglass frames and lenses or one (1) pair of contact lenses. Includes: eyeglasses/frames from the Davis Vision Collection covered in full. $200 allowance for eyewear purchased from Visionworks; $150 allowance for all other eyewear purchased at a Davis Vision network provider. $150 allowance for contact lenses purchased in lieu of frames and lenses.
Routine Hearing Services†		
Routine hearing exam copay	$10; one routine hearing exam per year	$10; one routine hearing exam per year
Hearing aid fitting and evaluations copay	$0 copay	$0 copay
Standard digital hearing aids	$699 copay per hearing aid (one per ear/per year)	$499 copay per hearing aid (one per ear/per year)
Premium digital hearing aids	$999 copay per hearing aid (one per ear/per year)	$799 copay per hearing aid (one per ear/per year)

*Choice and Choice Plus not available for KS65 Preferred HMO.
**Members must use a United Concordia network dental provider.
†Hearing services and aids are only covered when provided by TruHearing providers.
‡For out-of-network benefits on Choice and Choice Plus, there is an 80% coinsurance for most dental and vision benefits.

By enrolling, you'll have access to:

Nurse and Health Coach support

- Nursing Hotline — Access to nurses 24/7 for case management and chronic diseases.
- Health Coach — 24/7 access to personalized help from a Health Coach in coordinating care and reaching health goals.

SilverSneakers®* Fitness Program

- Enjoy access to classes, pools, free weights, treadmills, and more.
- Access to over 13,000 fitness locations nationwide at no extra cost.
- Expand your circle of friends and enjoy social activities.

Worldwide Emergency Care

Your membership includes coverage for emergency and urgent care when you travel.

Save up to $120 per year on OTC items!

Your plan includes a $30 per quarter allowance (every three months starting January 1, 2020) that's good toward your purchase of over-the-counter (OTC) items. Choose from hundreds of items, including:

- Vitamins and supplements
- Health and beauty supplies
- First-aid supplies
- Cough and cold medications
- Allergy medications
- And more

Telemedicine Benefit offered through MDLIVE

Plan members get 24/7 access to a doctor over the phone or online for a $5 copay.

This benefit offers a convenient way to see a physician for non-emergency medical conditions, such as colds, flu, rashes, and sinus infections, without leaving your home. This does not replace your PCP but allows additional access to care when you need it, and your PCP can receive your medical history as well. Services are available 24 hours a day, 7 days a week, either by toll-free phone number, or on a secure connection over the Internet via a smartphone, tablet, or computer.

Your MedigapFreedom Plan Choices		Plan A	Plan B	Plan G/ Plan G High Deductible*	Plan N
Service Category	**Medicare pays**	**You pay:**			
Primary Care Physician Visits Specialist Visits Emergency Room Urgent Care Outpatient Surgery	80% of Medicare-approved amounts after $198† annual Part B deductible is met	$198† Part B deductible (Plan pays 20% coinsurance)			$198† Part B deductible; up to a $20 copay for doctor visits; up to a $50 copay for emergency room (waived if admitted) (Plan pays all other Part B coinsurance)
Inpatient Hospital	All charges except $1,408† (Part A deductible) and Part A coinsurance	$1,408† (Part A deductible)	$0	$0	$0
Part B Excess Charges‡	Nothing	100%	100%	100%	Nothing
Prescription Drugs (Part D)	Nothing	Prescription Drug coverage is not included			

MedigapFreedom:

COVERED PERSON means a Medicare beneficiary who is enrolled in Medicare Part A and Part B, made the appropriate payment in consideration for this Policy, and is eligible for benefits under this Policy. Non-Tobacco rates apply to applications submitted during the 6-month open enrollment or in a guaranteed issue situation. Applicants NOT enrolling during the 6-month open enrollment period or in a guaranteed issue situation will be evaluated for tobacco usage and charged the corresponding tobacco or non-tobacco rates. All rates are subject to change with the approval of the Pennsylvania Insurance Department. Any rate change will apply to all policies in our service area and cannot be changed or canceled because of poor health. QCC Insurance Company has the right to change premiums based on your attained age and the table of rate changes. We will give a 30-day notice of a premium change.

Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East and QCC Insurance Company — independent licensees of the Blue Cross and Blue Shield Association.

To join, you must be enrolled in Medicare Parts A and B. You must continue to pay Medicare Part A (if applicable) and Part B premiums.

*Plan G High Deductible requires first paying a plan deductible of $2,340 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 plan G counts your payment of the Medicare Part B deductible toward meeting the plan deductible. The calendar year deductible is subject to change in 2021.

†This is the 2020 amount and may change on January 1, 2021. Each year, Social Security notifies all Medicare beneficiaries of the new Part A deductible and coinsurance, Part B deductible, and Part B premium amount.

‡If the amount a doctor or other health care provider charges is higher than the Medicare-approved amount, the difference is called the excess charge.

MedigapFreedom NON-TOBACCO PREMIUMS

Male Non-Tobacco Premiums						Female Non-Tobacco Premiums				
Plan A	Plan B	Plan G	Plan G-HD	Plan N		Plan A	Plan B	Plan G	Plan G-HD	Plan N
$131.08	$159.06	$181.55	$68.15	$139.97	Under 65*	$119.16	$144.60	$165.05	$61.95	$127.25
$131.08	$159.06	$181.55	$68.15	$139.97	65–67	$119.16	$144.60	$165.05	$61.95	$127.25
$137.04	$166.30	$189.66	$71.25	$146.69	68	$124.58	$151.18	$172.42	$64.77	$133.35
$142.65	$173.10	$197.09	$74.16	$153.02	69	$129.68	$157.36	$179.17	$67.42	$139.11
$148.61	$180.33	$206.04	$77.26	$160.62	70	$135.10	$163.94	$187.31	$70.24	$146.02
$154.93	$188.01	$214.99	$80.55	$168.22	71	$140.85	$170.91	$195.45	$73.23	$152.93
$160.42	$194.66	$222.93	$83.40	$174.93	72	$145.84	$176.97	$202.67	$75.82	$159.03
$165.31	$200.60	$231.38	$85.94	$182.41	73	$150.28	$182.36	$210.34	$78.13	$165.82
$169.48	$205.66	$238.64	$88.11	$188.74	74	$154.08	$186.97	$216.94	$80.10	$171.58
$174.02	$211.16	$246.58	$90.47	$195.83	75	$158.20	$191.97	$224.16	$82.24	$178.03
$177.60	$215.50	$253.67	$92.33	$202.04	76	$161.45	$195.91	$230.61	$83.94	$183.67
$181.29	$219.99	$261.95	$94.25	$209.39	77	$164.81	$199.99	$238.13	$85.68	$190.35
$185.71	$225.35	$271.40	$96.55	$218.00	78	$168.82	$204.86	$246.73	$87.77	$198.18
$188.21	$228.39	$277.65	$97.85	$223.58	79	$171.10	$207.62	$252.41	$88.95	$203.25
$189.40	$229.83	$283.39	$98.47	$228.77	80	$172.18	$208.94	$257.63	$89.52	$207.97
$192.27	$233.31	$293.02	$99.96	$237.76	81	$174.79	$212.10	$266.38	$90.87	$216.15
$195.01	$236.64	$303.66	$101.38	$247.64	82	$177.28	$215.12	$276.05	$92.17	$225.13
$195.49	$237.21	$311.09	$101.63	$254.74	83	$177.71	$215.65	$282.81	$92.39	$231.58
$195.61	$237.36	$318.02	$101.69	$261.45	84	$177.82	$215.78	$289.11	$92.45	$237.68
$197.18	$239.27	$324.60	$102.05	$267.91	85	$179.26	$217.52	$295.09	$92.77	$243.55
$200.98	$243.88	$330.85	$104.02	$274.24	86	$182.71	$221.71	$300.77	$94.56	$249.31
$205.29	$249.11	$337.94	$106.25	$281.08	87	$186.63	$226.46	$307.22	$96.59	$255.53
$207.54	$251.85	$341.66	$107.41	$284.63	88	$188.68	$228.95	$310.60	$97.65	$258.76
$210.73	$255.71	$346.90	$109.06	$290.08	89	$191.57	$232.46	$315.36	$99.15	$263.71
$215.34	$261.31	$354.50	$111.45	$297.93	90	$195.77	$237.55	$322.27	$101.32	$270.85
$220.88	$268.03	$363.62	$114.32	$306.92	91	$200.80	$243.66	$330.56	$103.92	$279.02
$221.31	$268.55	$372.74	$114.54	$315.79	92	$201.19	$244.13	$338.85	$104.12	$287.08
$228.88	$277.74	$376.79	$118.46	$319.97	93	$208.08	$252.49	$342.54	$107.69	$290.88
$231.86	$281.35	$381.69	$120.00	$324.91	94	$210.78	$255.77	$346.99	$109.09	$295.37
$234.83	$284.96	$386.58	$121.54	$329.73	95	$213.49	$259.06	$351.44	$110.49	$299.75
$237.40	$288.07	$390.81	$122.87	$334.16	96	$215.82	$261.89	$355.28	$111.70	$303.78
$241.30	$292.80	$397.22	$124.88	$340.62	97	$219.36	$266.19	$361.11	$113.53	$309.65
$244.58	$296.79	$402.63	$126.58	$346.07	98	$222.35	$269.81	$366.03	$115.08	$314.61
$247.86	$300.77	$408.03	$128.28	$351.51	99+	$225.33	$273.43	$370.94	$116.62	$319.56

To join, you must be enrolled in Medicare Parts A and B. You must continue to pay Medicare Part A (if applicable) and Part B premiums. Benefits underwritten by QCC Insurance Company, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

*This includes people under 65 on Medicare due to disability.

MedigapFreedom TOBACCO PREMIUMS

Male Tobacco Premiums						Female Tobacco Premiums				
Plan A	Plan B	Plan G	Plan G-HD	Plan N		Plan A	Plan B	Plan G	Plan G-HD	Plan N
$144.19	$174.97	$199.71	$74.96	$153.97	Under 65*	$131.08	$159.06	$181.55	$68.15	$139.97
$144.19	$174.97	$199.71	$74.96	$153.97	65–67	$131.08	$159.06	$181.55	$68.15	$139.97
$150.75	$182.93	$208.63	$78.37	$161.35	68	$137.04	$166.30	$189.66	$71.25	$146.69
$156.91	$190.41	$216.80	$81.58	$168.32	69	$142.65	$173.10	$197.09	$74.16	$153.02
$163.47	$198.37	$226.65	$84.99	$176.68	70	$148.61	$180.33	$206.04	$77.26	$160.62
$170.43	$206.81	$236.49	$88.60	$185.04	71	$154.93	$188.01	$214.99	$80.55	$168.22
$176.46	$214.13	$245.23	$91.74	$192.43	72	$160.42	$194.66	$222.93	$83.40	$174.93
$181.84	$220.66	$254.51	$94.54	$200.65	73	$165.31	$200.60	$231.38	$85.94	$182.41
$186.43	$226.23	$262.50	$96.92	$207.61	74	$169.48	$205.66	$238.64	$88.11	$188.74
$191.42	$232.28	$271.23	$99.52	$215.42	75	$174.02	$211.16	$246.58	$90.47	$195.83
$195.35	$237.05	$279.04	$101.56	$222.25	76	$177.60	$215.50	$253.67	$92.33	$202.04
$199.42	$241.99	$288.14	$103.68	$230.33	77	$181.29	$219.99	$261.95	$94.25	$209.39
$204.28	$247.88	$298.54	$106.20	$239.80	78	$185.71	$225.35	$271.40	$96.55	$218.00
$207.03	$251.22	$305.42	$107.63	$245.93	79	$188.21	$228.39	$277.65	$97.85	$223.58
$208.34	$252.82	$311.73	$108.32	$251.65	80	$189.40	$229.83	$283.39	$98.47	$228.77
$211.49	$256.64	$322.32	$109.95	$261.54	81	$192.27	$233.31	$293.02	$99.96	$237.76
$214.51	$260.30	$334.03	$111.52	$272.41	82	$195.01	$236.64	$303.66	$101.38	$247.64
$215.03	$260.94	$342.20	$111.79	$280.21	83	$195.49	$237.21	$311.09	$101.63	$254.74
$215.17	$261.09	$349.82	$111.86	$287.59	84	$195.61	$237.36	$318.02	$101.69	$261.45
$216.90	$263.20	$357.06	$112.26	$294.70	85	$197.18	$239.27	$324.60	$102.05	$267.91
$221.08	$268.27	$363.94	$114.42	$301.67	86	$200.98	$243.88	$330.85	$104.02	$274.24
$225.82	$274.02	$371.74	$116.87	$309.19	87	$205.29	$249.11	$337.94	$106.25	$281.08
$228.30	$277.03	$375.83	$118.16	$313.09	88	$207.54	$251.85	$341.66	$107.41	$284.63
$231.80	$281.28	$381.59	$119.97	$319.09	89	$210.73	$255.71	$346.90	$109.06	$290.08
$236.88	$287.44	$389.95	$122.59	$327.72	90	$215.34	$261.31	$354.50	$111.45	$297.93
$242.97	$294.83	$399.98	$125.75	$337.62	91	$220.88	$268.03	$363.62	$114.32	$306.92
$243.44	$295.40	$410.01	$125.99	$347.37	92	$221.31	$268.55	$372.74	$114.54	$315.79
$251.77	$305.51	$414.47	$130.30	$351.97	93	$228.88	$277.74	$376.79	$118.46	$319.97
$255.05	$309.49	$419.86	$132.00	$357.40	94	$231.86	$281.35	$381.69	$120.00	$324.91
$258.32	$313.46	$425.24	$133.69	$362.70	95	$234.83	$284.96	$386.58	$121.54	$329.73
$261.14	$316.88	$429.89	$135.15	$367.58	96	$237.40	$288.07	$390.81	$122.87	$334.16
$265.43	$322.08	$436.95	$137.37	$374.68	97	$241.30	$292.80	$397.22	$124.88	$340.62
$269.04	$326.47	$442.89	$139.24	$380.67	98	$244.58	$296.79	$402.63	$126.58	$346.07
$272.65	$330.85	$448.84	$141.11	$386.66	99+	$247.86	$300.77	$408.03	$128.28	$351.51

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