



Medicare Supplement insurance can be sold in only 12 standard plans plus two high-deductible plans. These charts show the benefits included in each plan. Every company must make available Plan A. Some plans may not be available in Texas.

BASIC BENEFITS for Plans A-J:

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.

Blood: First three pints of blood each year.

	A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	X	X	X	X	X	X	X	X	X	X	X	X
Skilled Nursing Coinsurance			X	X	X	X	X	X	X	X	X	X
Part A Deductible		X	X	X	X	X	X	X	X	X	X	X
Part B Deductible			X			X					X	
Part B Excess						X (100%)	X (80%)			X (100%)	X (100%)	
Foreign Travel Emergency			X	X	X	X	X	X	X	X	X	X
At-Home Recovery				X				X		X	X	
Preventive Care NOT covered by Medicare					X						X	

Medicare Select Plans require that you use a Blue Cross and Blue Shield of Texas Network Hospital for non-emergency admissions to receive coverage for the Medicare Part A deductible. Only certain hospitals are Network Hospitals under this policy. Plan A is not available for Medicare Select.

* Plans F and J also have an option called a high-deductible Plan F and a high-deductible Plan J. These high-deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar-year \$2,000 deductible. Benefits from high-deductible Plans F and J will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.



Outline of Medicare Supplement Coverage – Cover Page: 2 of 2
 Basic Benefits for Standard and Medicare Select Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits at different levels.

	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
Annual Out-of-Pocket Limit	\$4,620***	\$2,310***

** Plans K and L provide for different cost-sharing for items and services from Plans A–J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges.” You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation.

2010 MEDICARE SUPPLEMENT MONTHLY RATES BY AREA

3-Digit Zips for Area 1:

754-759,
763-769,
778-792,
795-799,
885

Area 1 Rates By Plan:

AGES	OPTION	A	D	F	G	K	L
65-66	Standard	\$176.00	\$120.00	\$131.00	\$118.00	\$66.00	\$93.00
	Medicare Select	N/A	\$104.00	\$114.00	\$102.00	\$63.00	\$88.00
67-69	Standard	\$204.00	\$141.00	\$149.00	\$134.00	\$76.00	\$108.00
	Medicare Select	N/A	\$125.00	\$132.00	\$119.00	\$75.00	\$105.00
70-74	Standard	\$239.00	\$167.00	\$176.00	\$158.00	\$89.00	\$127.00
	Medicare Select	N/A	\$140.00	\$146.00	\$132.00	\$84.00	\$115.00
75-79	Standard	\$267.00	\$186.00	\$197.00	\$178.00	\$100.00	\$142.00
	Medicare Select	N/A	\$149.00	\$158.00	\$142.00	\$87.00	\$122.00
80-84	Standard	\$302.00	\$209.00	\$223.00	\$201.00	\$115.00	\$160.00
	Medicare Select	N/A	\$164.00	\$175.00	\$156.00	\$95.00	\$132.00
85+	Standard	\$326.00	\$227.00	\$241.00	\$217.00	\$123.00	\$174.00
	Medicare Select	N/A	\$178.00	\$189.00	\$169.00	\$104.00	\$142.00

3-Digit Zips for Area 2:

750-753,
760-762,
770-777,
793-794

Area 2 Rates By Plan:

AGES	OPTION	A	D	F	G	K	L
65-66	Standard	\$193.00	\$136.00	\$143.00	\$129.00	\$74.00	\$104.00
	Medicare Select	N/A	\$117.00	\$124.00	\$113.00	\$70.00	\$97.00
67-69	Standard	\$224.00	\$155.00	\$165.00	\$149.00	\$85.00	\$119.00
	Medicare Select	N/A	\$138.00	\$146.00	\$132.00	\$84.00	\$115.00
70-74	Standard	\$265.00	\$182.00	\$194.00	\$175.00	\$98.00	\$139.00
	Medicare Select	N/A	\$153.00	\$161.00	\$146.00	\$90.00	\$127.00
75-79	Standard	\$293.00	\$205.00	\$220.00	\$197.00	\$113.00	\$157.00
	Medicare Select	N/A	\$164.00	\$177.00	\$158.00	\$98.00	\$134.00
80-84	Standard	\$337.00	\$232.00	\$247.00	\$222.00	\$125.00	\$178.00
	Medicare Select	N/A	\$182.00	\$192.00	\$174.00	\$106.00	\$146.00
85+	Standard	\$359.00	\$251.00	\$266.00	\$240.00	\$136.00	\$193.00
	Medicare Select	N/A	\$196.00	\$208.00	\$188.00	\$115.00	\$158.00

2010 MEDICARE SUPPLEMENT MONTHLY RATES BY AREA

Area 3:
out-of-state

Area 3 Rates By Plan:

AGES	OPTION	A	D	F	G	K	L
65-66	Standard	\$214.00	\$151.00	\$160.00	\$144.00	\$82.00	\$115.00
	Medicare Select	N/A	\$130.00	\$138.00	\$124.00	\$77.00	\$108.00
67-69	Standard	\$246.00	\$171.00	\$182.00	\$163.00	\$92.00	\$131.00
	Medicare Select	N/A	\$152.00	\$160.00	\$144.00	\$91.00	\$128.00
70-74	Standard	\$289.00	\$201.00	\$212.00	\$192.00	\$109.00	\$153.00
	Medicare Select	N/A	\$168.00	\$178.00	\$160.00	\$102.00	\$138.00
75-79	Standard	\$327.00	\$227.00	\$240.00	\$216.00	\$122.00	\$174.00
	Medicare Select	N/A	\$182.00	\$193.00	\$174.00	\$106.00	\$148.00
80-84	Standard	\$368.00	\$256.00	\$272.00	\$246.00	\$139.00	\$196.00
	Medicare Select	N/A	\$200.00	\$212.00	\$192.00	\$118.00	\$161.00
85+	Standard	\$396.00	\$277.00	\$294.00	\$265.00	\$150.00	\$211.00
	Medicare Select	N/A	\$216.00	\$230.00	\$207.00	\$128.00	\$174.00

PREMIUM INFORMATION: Blue Cross and Blue Shield of Texas can only raise your premium if we raise the premium for all policies like yours in this state. We will not change your premium or cancel your policy because of poor health. Premiums change at ages 67, 70, 75, 80 and 85. Premiums also change if you change your primary place of residence. If your premium changes, you will be notified at least 30 days in advance.

You have the option to purchase any of the Medicare Supplement benefit plans shown on the front cover in white as Standard Plans or as Medicare Select Plans, with the exception of Plan A which is available as a **Standard Plan** only. Check with your Physician to determine if he or she has admitting privileges at a Network Hospital. If he or she does not, you may be required to use another Physician at the time of hospitalization or you will be required to pay the Part A Deductible. Medicare Select Plans require that you use a Blue Cross and Blue Shield of Texas Network Medicare Select hospital for non-emergency admissions to receive coverage for the Medicare Part A deductible.

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 Texas.

RIGHT TO RETURN YOUR POLICY

If you find that you are not satisfied with your policy, you may return it to Blue Cross and Blue Shield of Texas, P.O. Box 660717, Dallas, TX 75266-0717. 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 will return all of your payments.

POLICY REPLACEMENT

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

NOTICE

This policy may not fully cover all of your medical costs. Neither Blue Cross and Blue Shield of Texas 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 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 age and medical history. Blue Cross and Blue Shield of Texas will void (rescind) your policy back to its effective date and refuse to pay any claims if you leave out or falsify important information (age and medical history). Also, any claims paid will be deducted from any premium refund that may be due. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

LIMITATIONS AND EXCLUSIONS

Your Medicare Supplement policy will not contain limitations and exclusions that are more restrictive than the limitations and exclusions contained in Medicare. The limitations and exclusions include:

- Charges for any services or supplies to the extent those charges are covered under Medicare; and

- Charges for any services or supplies provided to you prior to your effective date under the policy.

SUSPENSION AND/OR REFUND OF PREMIUM

Benefits and premiums under this policy may be suspended for up to 24 months if you become entitled to benefits under Medicaid. You must request that your policy be suspended within 90 days of becoming entitled to Medicaid. If you lose (are no longer entitled to) benefits from Medicaid, this policy can be reinstated if you request reinstatement within 90 days of the loss of such benefits and pay the required premium.

Upon termination of this Policy in any manner, including death of the Subscriber, Blue Cross and Blue Shield of Texas will refund to the Subscriber or his personal representative any portion of the premium previously paid which is applicable to Policy months following the month in which the termination occurred. (See discussion above if rescission occurs.)

MEDICARE SELECT ADDITIONAL DISCLOSURES

GRIEVANCE PROCEDURES

Grievance means dissatisfaction expressed in writing by a Subscriber under a Medicare Select policy with the administration, claims practices, or provisions of services concerning a Medicare Select Issuer or its Network Hospitals.

Grievance Procedures: You have the right to submit a grievance to us if you are dissatisfied with any aspect of processing your coverage. Write to the Issuer at the following address within 60 days of the date you are notified of any adverse action:

Grievance Committee
Blue Cross and Blue Shield of Texas
Medicare Select Program
P.O. Box 1637
Chicago, IL 60690-1637

Out-of-Hospital Grievances: All grievances will be addressed immediately and resolved as soon as possible. The Subscriber should write to us within 60 days of the date he is notified of any adverse action.

In-Hospital Grievances relating to ongoing Hospital treatment will be addressed immediately on receipt of any written or oral grievance and will be resolved as quickly as possible in a manner which does not interfere with, obstruct or interrupt continued medical treatment and care of the Subscriber.

Your grievance will be reviewed by a committee of Blue Cross and Blue Shield of Texas technical and management personnel who have the authority to take corrective action, if warranted. Any corrective action will be taken promptly and all concerned parties will be notified.

If you are dissatisfied with the decision of our Grievance Committee you may submit a written complaint to the Texas

For questions, please call the toll-free number that appears on the application and throughout the information packet.

*Plans K and L provide for different cost-sharing for items and services from Plans A–J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges.” You will be responsible for paying excess charges.

The out-of-pocket annual limit will increase each year for inflation.

Department of Insurance, P.O. Box 149104, Austin, Texas
78714-9104, fax (512) 475-1771 or email at
ConsumerProtection@tdi.state.tx.us.

QUALITY ASSURANCE

As part of our Quality Assurance program, all network hospitals must meet Medicare standards. In addition, hospitals must meet the contract criteria stated in the Hospital Agreement.

Each hospital must: agree to maintain its state license; agree to maintain its Blue Cross and Blue Shield of Texas Plan Hospital status; agree to maintain its Medicare participating status; be accredited and maintain its accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA); and agree to waive the Part A deductible.

MEDICARE SELECT HOSPITAL RESTRICTIONS

Plans D, F, G, K and L are available as standard or Medicare Select. The Part A deductible benefit may be restricted if you receive services in a hospital that is not a Medicare Select Network Hospital.

The full Part A deductible benefits of your coverage, excluding Plan K & L coinsurance*, will be paid anywhere if:

1. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or condition and it is not reasonable to obtain such services from a Medicare Select Hospital (such as while you are traveling); or
2. Covered services are not available through a Medicare Select Hospital.

Plan A

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

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

**\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

† 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.

SERVICES	MEDICARE PAYS	PLAN A PAYS	WITH PLAN A YOU PAY
HOSPITALIZATION* — Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: – Additional 365 days – Beyond the additional 365 days	All but \$1,100 All but \$275 a day All but \$550 a day \$0 \$0	\$0 \$275 a day \$550 a day 100% of Medicare-eligible expenses \$0	\$1,100 (Part A deductible) \$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 21st through 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 \$0 \$0	\$0** Up to \$137.50 a day All costs
BLOOD — First three pints Additional amounts	\$0 100%	Three pints \$0	\$0** \$0**

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD *(continued)*

<p>HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>
--	---	------------	----------------

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

* Once you have been billed \$155 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.

** \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

† By law, no physician may charge more than 115% of Medicare-approved amounts.

SERVICES	MEDICARE PAYS	PLAN A PAYS	WITH PLAN A YOU PAY
<p>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</p> <p>First \$155 of Medicare-approved amounts*</p> <p>Preventive benefits for Medicare-covered services</p> <p>Remainder of Medicare-approved amounts</p> <p>Part B excess charges (above Medicare-approved amounts)†</p>	<p>\$0</p> <p>Generally 75% or more of Medicare-approved amounts</p> <p>Generally 80%</p> <p>\$0</p>	<p>\$0</p> <p>Remainder of Medicare-approved amounts</p> <p>Generally 20%</p> <p>\$0</p>	<p>\$155 (Part B deductible)</p> <p>\$0**</p> <p>\$0**</p> <p>All costs</p>
<p>BLOOD —</p> <p>First three pints</p> <p>Next \$155 of Medicare-approved amounts*</p> <p>Remainder of Medicare-approved amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All costs</p> <p>\$0</p> <p>20%</p>	<p>\$0**</p> <p>\$155 (Part B deductible)</p> <p>\$0**</p>
<p>CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0**</p>

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN A PAYS	WITH PLAN A YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0** \$155 (Part B deductible) \$0**
AT-HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan – Benefit for each visit – Number of visits covered (must be received within eight weeks of last Medicare-approved visit) – Calendar-year maximum	\$0 \$0 \$0	\$0 \$0 \$0	All costs All costs All costs

OTHER BENEFITS — NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	PLAN A PAYS	WITH PLAN A YOU PAY
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services needed immediately because of an injury or illness of sudden and unexpected onset, beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 \$0	\$250 All costs

Plan D

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

- * A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
- ** \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.
- † 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.

SERVICES	MEDICARE PAYS	PLAN D PAYS	WITH PLAN D YOU PAY
HOSPITALIZATION* — Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: – Additional 365 days – Beyond the additional 365 days	All but \$1,100 All but \$275 a day All but \$550 a day \$0 \$0	\$1,100 (Part A deductible) ¹ \$275 a day \$550 a day 100% of Medicare-eligible expenses \$0	\$0** \$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 21st through 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0** \$0** All costs
BLOOD — First three pints Additional amounts	\$0 100%	Three pints \$0	\$0** \$0**

¹Medicare Select Plans require that you use a Blue Cross and Blue Shield of Texas Network Hospital for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the \$1,100 deductible is covered at any hospital from which you receive care.

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD *(continued)*

<p>HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>
--	---	------------	----------------

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

* Once you have been billed \$155 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.

** \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

† By law, no physician may charge more than 115% of Medicare-approved amounts.

SERVICES	MEDICARE PAYS	PLAN D PAYS	WITH PLAN D YOU PAY
<p>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</p> <p>First \$155 of Medicare-approved amounts*</p> <p>Preventive benefits for Medicare-covered services</p> <p>Remainder of Medicare-approved amounts</p> <p>Part B excess charges (above Medicare-approved amounts)†</p>	<p>\$0</p> <p>Generally 75% or more of Medicare-approved amounts</p> <p>Generally 80%</p> <p>\$0</p>	<p>\$0</p> <p>Remainder of Medicare-approved amounts</p> <p>Generally 20%</p> <p>\$0</p>	<p>\$155 (Part B deductible)</p> <p>\$0**</p> <p>\$0**</p> <p>All costs</p>
<p>BLOOD —</p> <p>First three pints</p> <p>Next \$155 of Medicare-approved amounts*</p> <p>Remainder of Medicare-approved amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All costs</p> <p>\$0</p> <p>20%</p>	<p>\$0**</p> <p>\$155 (Part B deductible)</p> <p>\$0**</p>
<p>CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0**</p>

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN D PAYS	WITH PLAN D YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0** \$155 (Part B deductible) \$0**
AT-HOME RECOVERY SERVICES NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan – Benefit for each visit – Number of visits covered (must be received within eight weeks of last Medicare-approved visit) – Calendar-year maximum	\$0 \$0 \$0	Actual charges to \$40 a visit Up to the number of Medicare-approved visits, not to exceed seven each week \$1,600	Balance Balance Balance
OTHER BENEFITS — NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	PLAN D PAYS	WITH PLAN D YOU PAY
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services needed immediately because of an injury or illness of sudden and unexpected onset, beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

Plan F

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

- * A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
- **\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.
- + 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.

SERVICES	MEDICARE PAYS	PLAN F PAYS	WITH PLAN F YOU PAY
HOSPITALIZATION* — Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: – Additional 365 days – Beyond the additional 365 days	All but \$1,100 All but \$275 a day All but \$550 a day \$0 \$0	\$1,100 (Part A deductible) ¹ \$275 a day \$550 a day 100% of Medicare-eligible expenses \$0	\$0** \$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 21st through 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0** \$0** All costs
BLOOD — First three pints Additional amounts	\$0 100%	Three pints \$0	\$0** \$0**

¹Medicare Select Plans require that you use a Blue Cross and Blue Shield of Texas Network Hospital for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the \$1,100 deductible is covered at any hospital from which you receive care.

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD *(continued)*

<p>HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>
--	---	------------	----------------

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

* Once you have been billed \$155 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.

** \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

† By law, no physician may charge more than 115% of Medicare-approved amounts.

SERVICES	MEDICARE PAYS	PLAN F PAYS	WITH PLAN F YOU PAY
<p>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</p> <p>First \$155 of Medicare-approved amounts*</p> <p>Preventive benefits for Medicare-covered services</p> <p>Remainder of Medicare-approved amounts</p> <p>Part B excess charges (above Medicare-approved amounts)†</p>	<p>\$0</p> <p>Generally 75% or more of Medicare-approved amounts</p> <p>Generally 80%</p> <p>\$0</p>	<p>\$155 (Part B deductible)</p> <p>Remainder of Medicare-approved amounts</p> <p>Generally 20%</p> <p>100%</p>	<p>\$0**</p> <p>\$0**</p> <p>\$0**</p> <p>\$0**</p>
<p>BLOOD —</p> <p>First three pints</p> <p>Next \$155 of Medicare-approved amounts*</p> <p>Remainder of Medicare-approved amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All costs</p> <p>\$155 (Part B deductible)</p> <p>20%</p>	<p>\$0**</p> <p>\$0**</p> <p>\$0**</p>
<p>CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0**</p>

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN F PAYS	WITH PLAN F YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$155 (Part B deductible) 20%	\$0** \$0** \$0**
AT-HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan – Benefit for each visit – Number of visits covered (must be received within eight weeks of last Medicare-approved visit) – Calendar-year maximum	\$0 \$0 \$0	\$0 \$0 \$0	All costs All costs All costs

OTHER BENEFITS — NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	PLAN F PAYS	WITH PLAN F YOU PAY
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services needed immediately because of an injury or illness of sudden and unexpected onset, beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

Plan G

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

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

** \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

+ 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.

SERVICES	MEDICARE PAYS	PLAN G PAYS	WITH PLAN G YOU PAY
HOSPITALIZATION* — Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: – Additional 365 days – Beyond the additional 365 days	All but \$1,100 All but \$275 a day All but \$550 a day \$0 \$0	\$1,100 (Part A deductible) ¹ \$275 a day \$550 a day 100% of Medicare-eligible expenses \$0	\$0** \$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 21st through 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0** \$0** All costs
BLOOD — First three pints Additional amounts	\$0 100%	Three pints \$0	\$0** \$0**

¹Medicare Select Plans require that you use a Blue Cross and Blue Shield of Texas Network Hospital for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the \$1,100 deductible is covered at any hospital from which you receive care.

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD *(continued)*

<p>HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>
--	---	------------	----------------

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

* Once you have been billed \$155 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.

** \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

† By law, no physician may charge more than 115% of Medicare-approved amounts.

SERVICES	MEDICARE PAYS	PLAN G PAYS	WITH PLAN G YOU PAY
<p>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</p>	<p>\$0</p> <p>Generally 75% or more of Medicare-approved amounts</p> <p>Generally 80%</p> <p>\$0</p>	<p>\$0</p> <p>Remainder of Medicare-approved amounts</p> <p>Generally 20%</p> <p>80%</p>	<p>\$155 (Part B deductible)</p> <p>\$0**</p> <p>\$0**</p> <p>20%</p>
<p>First \$155 of Medicare-approved amounts*</p>			
<p>Preventive benefits for Medicare-covered services</p>			
<p>Remainder of Medicare-approved amounts</p>			
<p>Part B excess charges (above Medicare-approved amounts)†</p>			
<p>BLOOD —</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All costs</p> <p>\$0</p> <p>20%</p>	<p>\$0**</p> <p>\$155 (Part B deductible)</p> <p>\$0**</p>
<p>First three pints</p>			
<p>Next \$155 of Medicare-approved amounts*</p>			
<p>Remainder of Medicare-approved amounts</p>			
<p>CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0**</p>

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN G PAYS	WITH PLAN G YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0** \$155 (Part B deductible) \$0**
AT-HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan – Benefit for each visit – Number of visits covered (must be received within eight weeks of last Medicare-approved visit) – Calendar-year maximum	\$0 \$0 \$0	Actual charges to \$40 a visit Up to the number of Medicare-approved visits, not to exceed seven each week \$1,600	Balance Balance Balance
OTHER BENEFITS — NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	PLAN G PAYS	WITH PLAN G YOU PAY
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services needed immediately because of an injury or illness of sudden and unexpected onset, beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

Plan K

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

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

** \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

◆ You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4,620 each calendar year. The amounts that count toward your annual limit are noted with diamonds(◆).

+ 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.

SERVICES	MEDICARE PAYS	PLAN K PAYS	WITH PLAN K YOU PAY
HOSPITALIZATION* — Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: – Additional 365 days – Beyond the additional 365 days	All but \$1,100 All but \$275 a day All but \$550 a day \$0 \$0	\$550 (50% of Part A deductible) ¹ \$275 a day \$550 a day 100% of Medicare-eligible expenses \$0	\$550◆ (50% of Part A deductible) \$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 21st through 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$68.75 a day \$0	\$0** Up to \$68.75 a day◆ All costs
BLOOD — First three pints Additional amounts	\$0 100%	50% \$0	50%◆ \$0**

¹Medicare Select Plans require that you use a Blue Cross and Blue Shield of Texas Network Hospital for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the \$1,100 deductible is covered at any hospital from which you receive care.

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD *(continued)*

HOSPICE CARE —

Available as long as your doctor certifies you are terminally ill and you elect to receive these services

All but very limited coinsurance for outpatient drugs and inpatient respite care

50% of coinsurance or copayments

50% of coinsurance or copayments♦

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

* Once you have been billed \$155 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.

** \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

† By law, no physician may charge more than 115% of Medicare-approved amounts.

♦ You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4,620 each calendar year. The amounts that count toward your annual limit are noted with diamonds(♦).

SERVICES	MEDICARE PAYS	PLAN K PAYS	WITH PLAN K YOU PAY
<p>MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment</p> <p>First \$155 of Medicare-approved amounts*</p> <p>Preventive benefits for Medicare-covered services</p> <p>Remainder of Medicare-approved amounts</p> <p>Part B excess charges (above Medicare-approved amounts)†</p>	<p>\$0</p> <p>Generally 75% or more of Medicare-approved amounts</p> <p>Generally 80%</p> <p>\$0</p>	<p>\$0</p> <p>Remainder of Medicare-approved amounts</p> <p>Generally 10%</p> <p>\$0</p>	<p>\$155 (Part B deductible)♦</p> <p>\$0**</p> <p>Generally 10%♦</p> <p>All costs</p>
<p>BLOOD —</p> <p>First three pints</p> <p>Next \$155 of Medicare-approved amounts*</p> <p>Remainder of Medicare-approved amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>50%</p> <p>\$0</p> <p>Generally 10%</p>	<p>50%♦</p> <p>\$155 (Part B deductible)♦</p> <p>Generally 10%♦</p>
<p>CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0**</p>

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN K PAYS	WITH PLAN K YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 10%	\$0** \$155 (Part B deductible)◆ 10%◆
AT-HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan – Benefit for each visit – Number of visits covered (must be received within eight weeks of last Medicare-approved visit) – Calendar-year maximum	\$0 \$0 \$0	\$0 \$0 \$0	All costs All costs All costs

OTHER BENEFITS – NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	PLAN K PAYS	WITH PLAN K YOU PAY
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services needed immediately because of an injury or illness of sudden and unexpected onset, beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 \$0	\$250 All costs

Plan L

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

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

** \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

◆◆ You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,310 each calendar year. The amounts that count toward your annual limit are noted with diamonds(◆◆).

+ 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.

SERVICES	MEDICARE PAYS	PLAN L PAYS	WITH PLAN L YOU PAY
HOSPITALIZATION* — Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: – Additional 365 days – Beyond the additional 365 days	All but \$1,100 All but \$275 a day All but \$550 a day \$0 \$0	\$825 (75% of Part A deductible) ¹ \$275 a day \$550 a day 100% of Medicare-eligible expenses \$0	\$275◆◆ (25% of Part A deductible) \$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 21st through 100th day 101st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$103.12 a day \$0	\$0** Up to \$34.38 a day◆◆ All costs
BLOOD — First three pints Additional amounts	\$0 100%	75% \$0	25%◆◆ \$0**

¹Medicare Select Plans require that you use a Blue Cross and Blue Shield of Texas Network Hospital for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the \$1,100 deductible is covered at any hospital from which you receive care.

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD *(continued)*

<p>HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>75% of coinsurance or copayments</p>	<p>25% of coinsurance or copayments◆◆</p>
--	---	---	---

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

* Once you have been billed \$155 of Medicare-approved amounts for covered services (which are noted with a single asterisk), your Part B deductible will have been met for the calendar year.

** \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

† By law, no physician may charge more than 115% of Medicare-approved amounts.

◆◆ You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,310 each calendar year. The amounts that count toward your annual limit are noted with diamonds(◆◆).

SERVICES	MEDICARE PAYS	PLAN L PAYS	WITH PLAN L YOU PAY
<p>MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment</p>	<p>\$0</p> <p>Generally 75% or more of Medicare-approved amounts</p> <p>Generally 80%</p> <p>\$0</p>	<p>\$0</p> <p>Remainder of Medicare-approved amounts</p> <p>Generally 15%</p> <p>\$0</p>	<p>\$155 (Part B deductible)◆◆</p> <p>\$0**</p> <p>Generally 5%◆◆</p> <p>All costs</p>
<p>First \$155 of Medicare-approved amounts*</p> <p>Preventive benefits for Medicare-covered services</p> <p>Remainder of Medicare-approved amounts</p> <p>Part B excess charges (above Medicare-approved amounts)†</p>			
<p>BLOOD</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>75%</p> <p>\$0</p> <p>Generally 15%</p>	<p>25%◆◆</p> <p>\$155 (Part B deductible)◆◆</p> <p>Generally 5%◆◆</p>
<p>First three pints</p> <p>Next \$155 of Medicare-approved amounts*</p> <p>Remainder of Medicare-approved amounts</p>			
<p>CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0**</p>

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN L PAYS	WITH PLAN L YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment	100%	\$0	\$0**
First \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 80%	\$0 15%	\$155 (Part B deductible)◆◆ 5%◆◆
AT-HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan – Benefit for each visit – Number of visits covered (must be received within eight weeks of last Medicare-approved visit) – Calendar-year maximum	\$0 \$0 \$0	\$0 \$0 \$0	All costs All costs All costs

OTHER BENEFITS – NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	PLAN L PAYS	WITH PLAN L YOU PAY
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services needed immediately because of an injury or illness of sudden and unexpected onset, beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 \$0	\$250 All costs



**BlueCross BlueShield
of Texas**