BlueCross BlueShield TX Packet (GI)

Thank you for your interest in applying for the BlueCross BlueShield of Texas Medicare Supplement plan!

You have access to a copy of the policy Enrollment Form (downloadable .pdf) as well as a printable copy of the Outline of Coverage and also a link to their online application.

Should you decide to apply by upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to BlueCross BlueShield of Texas. You may upload, email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: client.services@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf)
Online application
Download Policy Outline (.pdf)
Download Application (.pdf)

Our website: http://www.medicare-texas.net

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

Outline of Medicare Supplement Coverage – Standard Benefit for Plan A and High Deductible Plan F and Standard and Medicare Select Benefit for Plan F, Plan G, Plan K, Plan L and Plan N

This chart shows the benefits included in each of the standard Medicare supplement plans sold for effective dates on or after June 1, 2010. Every company must make Plan "A" available. Blue Cross and Blue Shield of Texas does not offer those plans shaded in gray below.

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 3 pints of blood each year.
- Hospice - Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
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*		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	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% 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 A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit $4,940 ; paid at 100% after limit reached	Out-of-pocket limit $2,470 ; paid at 100% after limit reached		

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year $2,180 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,180. 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.

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 and High Deductible Plan F are not available for Medicare Select.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

JANUARY 1, 2015 MEDICARE SUPPLEMENT MONTHLY RATES BY AREA

Area 1 Rates By Plan:

3-Digit ZIP Codes for Area 1:
754-759, 763-769, 778-792, 795-799, 885

AGES	OPTION	A	F	F*	G	K	L	N
65-66	Standard	$204.00	$137.00	$45.00	$124.00	$69.00	$98.00	$98.00
	Medicare Select	N/A	$118.00	N/A	$107.00	$66.00	$92.00	$84.00
67-69	Standard	$235.00	$155.00	$51.00	$142.00	$78.00	$115.00	$110.00
	Medicare Select	N/A	$137.00	N/A	$126.00	$79.00	$110.00	$97.00
70-74	Standard	$277.00	$183.00	$59.00	$167.00	$93.00	$134.00	$130.00
	Medicare Select	N/A	$151.00	N/A	$140.00	$88.00	$120.00	$108.00
75-79	Standard	$308.00	$205.00	$67.00	$186.00	$104.00	$150.00	$146.00
	Medicare Select	N/A	$164.00	N/A	$150.00	$91.00	$127.00	$118.00
80-84	Standard	$350.00	$232.00	$75.00	$211.00	$119.00	$169.00	$166.00
	Medicare Select	N/A	$181.00	N/A	$165.00	$100.00	$139.00	$130.00
85+	Standard	$377.00	$251.00	$82.00	$228.00	$128.00	$183.00	$179.00
	Medicare Select	N/A	$196.00	N/A	$179.00	$109.00	$157.50.00	$140.00

Area 2 Rates By Plan:

3-Digit ZIP Codes for Area 2:
750-753, 760-762, 770-777, 793-794

AGES	OPTION	A	F	F*	G	K	L	N
65-66	Standard	$223.00	$149.00	$49.00	$136.00	$77.00	$110.00	$106.00
	Medicare Select	N/A	$128.00	N/A	$119.00	$74.00	$102.00	$92.00
67-69	Standard	$259.00	$172.00	$56.00	$156.00	$89.00	$125.00	$122.00
	Medicare Select	N/A	$151.00	N/A	$140.00	$88.00	$120.00	$108.00
70-74	Standard	$306.00	$202.00	$66.00	$183.00	$102.00	$147.00	$144.00
	Medicare Select	N/A	$167.00	N/A	$154.00	$95.00	$133.00	$120.00
75-79	Standard	$339.00	$229.00	$75.00	$207.00	$117.00	$167.00	$163.00
	Medicare Select	N/A	$183.00	N/A	$167.00	$103.00	$141.00	$131.00
80-84	Standard	$390.00	$257.00	$84.00	$233.00	$130.00	$188.00	$183.00
	Medicare Select	N/A	$199.00	N/A	$183.00	$110.00	$157.50.00	$142.00
85+	Standard	$415.00	$277.00	$90.00	$253.00	$141.00	$204.00	$197.00
	Medicare Select	N/A	$215.00	N/A	$198.00	$121.00	$166.00	$155.00

JANUARY 1, 2015 MEDICARE SUPPLEMENT MONTHLY RATES BY AREA

3-Digit ZIP Codes for Area 3:
out-of-state

Area 3 Rates By Plan:

AGES	OPTION	A	F	F*	G	K	L	N
65-66	Standard	$247.00	$166.00	$54.00	$151.00	$84.00	$121.00	$119.00
	Medicare Select	N/A	$143.00	N/A	$131.00	$80.00	$113.00	$103.00
67-69	Standard	$284.00	$189.00	$61.00	$172.00	$96.00	$139.00	$134.00
	Medicare Select	N/A	$166.00	N/A	$157.50.00	$96.00	$134.00	$119.00
70-74	Standard	$334.00	$220.00	$72.00	$202.00	$113.00	$162.00	$157.00
	Medicare Select	N/A	$184.00	N/A	$169.00	$107.00	$144.00	$132.00
75-79	Standard	$378.00	$250.00	$82.00	$227.00	$127.00	$183.00	$177.00
	Medicare Select	N/A	$200.00	N/A	$183.00	$110.00	$154.00	$143.00
80-84	Standard	$426.00	$283.00	$92.00	$259.00	$144.00	$207.00	$201.00
	Medicare Select	N/A	$220.00	N/A	$203.00	$124.00	$169.00	$157.00
85+	Standard	$458.00	$306.00	$100.00	$278.00	$156.00	$223.00	$218.00
	Medicare Select	N/A	$238.00	N/A	$219.00	$134.00	$181.00	$170.00

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 and High Deductible Plan F which are 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. Blue Cross and Blue Shield of Texas is not connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

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 3004
Naperville, IL 60566-9747
Fax: 888-235-2936

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 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 F, G, K, L and N 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.

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

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.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$0	$1,260 (Part A deductible)
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 a day	$0
– Once Lifetime Reserve days are used: – Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* 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 through 100th day	All but $157.50 a day	$0	Up to $157.50 a 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

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

Plan A

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

* Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan 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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

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.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$1,260 (Part A deductible)[1]	$0
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 a day	$0
– Once Lifetime Reserve days are used: – Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
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 through 100th day	All but $157.50 a day	Up to $157.50 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

**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.

[1] 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. In an emergency, the $1,260 deductible is covered at any hospital from which you receive care.

Plan F

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

* Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan 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 $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL —NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the 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

High Deductible 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.

This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year $2,180 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay $2,180 Deductible**, Plan Pays	In addition To $2,180 Deductible**, You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$1,260 (Part A deductible)	$0
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 a day	$0
– Once Lifetime Reserve days are used:			
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
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 through 100th day	All but $157.50 a day	Up to $157.50 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

***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.

High Deductible Plan F

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

* Once you have been billed $147 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.

This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year $2,180 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Services	Medicare Pays	After You Pay $2,180 Deductible**, Plan Pays	In addition To $2,180 Deductible**, 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 $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
MEDICARE (PARTS A & B)			
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of 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

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.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$1,260 (Part A deductible)[1]	$0
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 a day	$0
– Once Lifetime Reserve days are used:			
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
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 through 100th day	All but $157.50 a day	Up to $157.50 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

**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.

[1] 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. In an emergency, the $1,260 deductible is covered at any hospital from which you receive care.

Plan G

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

* Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan 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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the 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

Plan K

* You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $4,940 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, the limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (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.

Services	Medicare Pays	Plan Pays	You Pay*
HOSPITALIZATION**			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$630 (50% of Part A deductible)[1]	$630 (50% of Part A deductible)♦
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 a day	$0
– Once Lifetime Reserve days are used:			
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE**			
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 through 100th day	All but $157.50 a day	Up to $78.75 a day	Up to $78.75 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 Medicare copayment/ coinsurance	50% of Medicare copayment/ coinsurance♦

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

[1] 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. In an emergency, the $1,260 deductible is covered at any hospital from which you receive care.

Plan K

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

† This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $4,940 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.**

Services	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 $147 of Medicare-approved amounts****	$0	$0	$147 (Part B deductible)****♦
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 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 $4,940)†
BLOOD			
First 3 pints	$0	50%	50%♦
Next $147 of Medicare-approved amounts****	$0	$0	$147 (Part B deductible)****♦
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%♦
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan Pays	You Pay*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment First $147 of Medicare-approved amounts*****	$0	$0	$147 (Part B deductible)♦
Remainder of Medicare-approved amounts	80%	10%	10%♦

**** Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with asterisks), your Part B deductible will have been met for the calendar year.

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

Plan L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,470 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, the limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (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.

Services	Medicare Pays	Plan Pays	You Pay*
HOSPITALIZATION**			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$945 (75% of Part A deductible)[1]	$315 (25% of Part A deductible)♦
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 a day	$0
– Once Lifetime Reserve days are used:			
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE**			
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 through 100th day	All but $157.50 a day	Up to $118.13 a day	Up to $39.37 a day♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%♦
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of Medicare copayment/coinsurance	25% of Medicare copayment/coinsurance♦

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

[1] 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. In an emergency, the $1,260 deductible is covered at any hospital from which you receive care.

Plan L

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

† This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2,470 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.**

Services	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 $147 of Medicare-approved amounts****	$0	$0	$147 (Part B deductible)****♦
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $2,470)†
BLOOD			
First 3 pints	$0	75%	25%♦
Next $147 of Medicare-approved amounts****	$0	$0	$147 (Part B deductible)♦
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan Pays	You Pay*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment First $147 of Medicare-approved amounts*****	$0	$0	$147 (Part B deductible)♦
Remainder of Medicare-approved amounts	80%	15%	Generally 5%♦

**** Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with asterisks), your Part B deductible will have been met for the calendar year.

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

Plan N

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.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$1,260 (Part A deductible)[1]	$0
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 a day	$0
– Once Lifetime Reserve days are used:			
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
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 through 100th day	All but $157.50 a day	Up to $157.50 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

**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.

[1] 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. In an emergency, the $1,260 deductible is covered at any hospital from which you receive care.

Plan N

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

* Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan 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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 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.
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Plan N

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan Pays	You Pay
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the 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