BlueCross BlueShield of Texas

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 $5,560; paid at 100% after limit reached	Out-of-pocket limit $2,780; 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 $2,300 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,300. 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

MAY 1, 2019 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
Ages 65-66	Standard	$206.00	$166.00	$51.00	$151.00	$84.00	$118.00	$118.00
	Medicare Select	N/A	$142.00	N/A	$130.00	$81.00	$112.00	$103.00
Ages 67-69	Standard	$236.00	$187.00	$58.00	$172.00	$94.00	$139.00	$134.00
	Medicare Select	N/A	$166.00	N/A	$153.00	$96.00	$134.00	$117.00
Ages 70-74	Standard	$279.00	$222.00	$68.00	$202.00	$113.00	$163.00	$157.00
	Medicare Select	N/A	$183.00	N/A	$170.00	$107.00	$146.00	$132.00
Ages 75-79	Standard	$311.00	$249.00	$78.00	$225.00	$126.00	$182.00	$178.00
	Medicare Select	N/A	$199.00	N/A	$182.00	$111.00	$154.00	$142.00
Ages 80-84	Standard	$353.00	$282.00	$85.00	$255.00	$144.00	$205.00	$201.00
	Medicare Select	N/A	$220.00	N/A	$200.00	$120.00	$169.00	$157.00
Ages 85+	Standard	$379.00	$304.00	$94.00	$276.00	$155.00	$222.00	$217.00
	Medicare Select	N/A	$238.00	N/A	$217.00	$133.00	$180.00	$170.00

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
Ages 65-66	Standard	$204.00	$165.00	$52.00	$149.00	$84.00	$121.00	$117.00
	Medicare Select	N/A	$141.00	N/A	$131.00	$81.00	$113.00	$101.00
Ages 67-69	Standard	$237.00	$189.00	$59.00	$172.00	$98.00	$138.00	$134.00
	Medicare Select	N/A	$167.00	N/A	$153.00	$97.00	$132.00	$119.00
Ages 70-74	Standard	$280.00	$222.00	$70.00	$202.00	$113.00	$163.00	$159.00
	Medicare Select	N/A	$183.00	N/A	$170.00	$104.00	$146.00	$132.00
Ages 75-79	Standard	$310.00	$252.00	$79.00	$227.00	$129.00	$183.00	$179.00
	Medicare Select	N/A	$202.00	N/A	$183.00	$114.00	$154.00	$144.00
Ages 80-84	Standard	$356.00	$282.00	$89.00	$256.00	$143.00	$207.00	$202.00
	Medicare Select	N/A	$219.00	N/A	$202.00	$121.00	$168.00	$155.00
Ages 85+	Standard	$379.00	$305.00	$95.00	$278.00	$154.00	$224.00	$217.00
	Medicare Select	N/A	$237.00	N/A	$218.00	$133.00	$182.00	$171.00

MAY 1, 2019 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
Ages 65-66	**Standard**	$221.00	$178.00	$56.00	$163.00	$91.00	$130.00	$128.00
	Medicare Select	N/A	$153.00	N/A	$141.00	$87.00	$122.00	$111.00
Ages 67-69	**Standard**	$254.00	$203.00	$63.00	$185.00	$103.00	$149.00	$144.00
	Medicare Select	N/A	$178.00	N/A	$164.00	$103.00	$144.00	$128.00
Ages 70-74	**Standard**	$298.00	$237.00	$74.00	$217.00	$122.00	$174.00	$169.00
	Medicare Select	N/A	$198.00	N/A	$182.00	$115.00	$155.00	$142.00
Ages 75-79	**Standard**	$338.00	$269.00	$85.00	$244.00	$137.00	$197.00	$191.00
	Medicare Select	N/A	$215.00	N/A	$197.00	$118.00	$166.00	$153.00
Ages 80-84	**Standard**	$380.00	$305.00	$95.00	$279.00	$155.00	$222.00	$216.00
	Medicare Select	N/A	$237.00	N/A	$218.00	$134.00	$182.00	$169.00
Ages 85+	**Standard**	$408.00	$330.00	$103.00	$299.00	$168.00	$240.00	$235.00
	Medicare Select	N/A	$256.00	N/A	$236.00	$144.00	$195.00	$183.00

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.

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.)

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. Blue Cross and Blue Shield of Texas may cancel your policy and refuse to pay any claims if you leave out or falsify important information.

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

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 $1,364	$0	$1,364 (Part A deductible)
61st through 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 $185 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 $185 of Medicare-approved amounts*	$0	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$0	$185 (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 $1,364	$1,364 (Part A deductible)[1]	$0
61st through 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $1,364 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 $185 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 $185 of Medicare-approved amounts*	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$185 (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

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 $2,300 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,300. 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 $2,300 Deductible**, Plan Pays	In Addition to $2,300 Deductible**, You Pay
Hospitalization*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0
61st through 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $2,300 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,300. 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 $2,300 Deductible**, Plan Pays	In Addition to $2,300 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 $185 of Medicare-approved amounts*	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$185 (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 $1,364	$1,364 (Part A deductible)[1]	$0
61st through 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $1,364 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 $185 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 $185 of Medicare-approved amounts*	$0	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$0	$185 (Part B deductible)
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 K

* You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $5,560 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 $1,364	$682 (50% of Part A deductible)[1]	$682 (50% of Part A deductible)♦
61st through 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $85.25 a day	Up to $85.25 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 $1,364 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 $5,560 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 $185 of Medicare-approved amounts****	$0	$0	$185 (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 $5,560)†
Blood			
First 3 pints	$0	50%	50%♦
Next $185 of Medicare-approved amounts****	$0	$0	$185 (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 $185 of Medicare-approved amounts*****	$0	$0	$185 (Part B deductible)♦
Remainder of Medicare-approved amounts	80%	10%	10%♦

**** Once you have been billed $185 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 $2,780 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 $1,364	$1,023 (75% of Part A deductible)[1]	$341 (25% of Part A deductible)♦
61st through 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $127.88 a day	Up to $42.62 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 $1,364 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 $2,780 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 $185 of Medicare-approved amounts****	$0	$0	$185 (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 $2,780)†
Blood			
First 3 pints	$0	75%	25%♦
Next $185 of Medicare-approved amounts****	$0	$0	$185 (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 $185 of Medicare-approved amounts*****	$0	$0	$185 (Part B deductible)♦
Remainder of Medicare-approved amounts	80%	15%	Generally 5%♦

**** Once you have been billed $185 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 $1,364	$1,364 (Part A deductible)[1]	$0
61st through 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $1,364 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 $185 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 $185 of Medicare-approved amounts*	$0	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$0	$185 (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 $185 of Medicare-approved amounts*	$0	$0	$185 (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

BlueCross BlueShield of Texas

Application for Medicare Supplement Insurance Plan

Instructions

1. To be considered for coverage, you must have Medicare Parts A and B, reside in Texas, and be: a) age 65 or over or b) applying within 6 months of your Medicare Part B effective date.
2. **If submitting a paper application, please complete in ink. Be sure to sign and date on the appropriate line(s) on pages 3, 4, and 8.** Send no money now! No payment is due until you have a chance to review your policy and make sure the coverage is right for you.
3. If you meet the eligibility requirements for under age 65 disability, you are only eligible for Plan A.

HOME OFFICE USE ONLY

Plan Selection *Check one box to apply for a Medicare Supplement Insurance plan.*

- ☐ **Plan A**
- **Plan F**
  - ☐ Standard
  - ☐ Medicare Select
- ☐ **Plan F High Deductible**
- **Plan G**
  - ☐ Standard
  - ☐ Medicare Select
- **Plan K**
  - ☐ Standard
  - ☐ Medicare Select
- **Plan L**
  - ☐ Standard
  - ☐ Medicare Select
- **Plan N**
  - ☐ Standard
  - ☐ Medicare Select

Requested Policy Effective Date ☐☐ ☐☐ ☐☐☐☐ *MONTH DAY YEAR*

See the enclosed Outline of Coverage for rate information

Applicant Information

Preferred Method of Contact: ☐ Mail ☐ Phone ☐ Email

Name *(First)*	*(Middle)*	*(Last)*		
Home Address (No P.O. Boxes)		City	State **TX**	ZIP
Correspondence/Billing Address		City	State	ZIP
Primary Phone ( )	Secondary Phone ( )	Age	Date of Birth ___ ___/___ ___/___ ___ ___ ___ Mo. Day Year	
Gender Male ☐ Female ☐	Social Security Number ___ ___ ___ -___ ___ -___ ___ ___ ___	Email address		

Payment Option *(Select one payment option)*

1. ☐ Premium **deducted from bank account**: *(choose one)*: ☐ ***Checking*** ☐ ***Savings***

   Account holder name: _____

   Bank name: _____

   Bank routing #: _____ Bank account #: _____

   Account Owner Signature *(if different than applicant)* **X** _____

2. ☐ Premium **to be billed by mail**

3. I will pay my premium: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Applicant Name _____

Medicare Beneficiary Identifier

Please copy the Medicare Beneficiary Identifier from your red, white and blue Medicare Card. This number must be provided to us to complete your application process.

Medicare Beneficiary Identifier ☐☐☐☐☐☐☐☐☐☐☐

Part A Effective Date: ___/01/_____

Part B Effective Date: ___/01/_____

Consumer Protection Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. ***Please include a copy of the notice from your prior insurer with your application.***

PLEASE ANSWER ALL QUESTIONS. Please mark Yes or No below with an "X" to the best of your knowledge.

1. Did you turn age 65 in the last 6 months? Yes ☐ No ☐

2. Did you enroll in Medicare Part B in the last 6 months? Yes ☐ No ☐

If yes, what is the effective date? ___/___/_____

3. Are you covered for medical assistance through the state Medicaid program?

NOTE TO APPLICANT: *If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.* Yes ☐ No ☐

a. If yes, will Medicaid pay your premiums for this Medicare Supplement policy? Yes ☐ No ☐

b. If yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes ☐ No ☐

4. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates. *(If you are still covered under this plan, leave "END" blank.)*

Start: ___/___/_____

End: ___/___/_____

a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? Yes ☐ No ☐

b. Was this your first time in this type of Medicare plan? Yes ☐ No ☐

c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes ☐ No ☐

5. Do you have another Medicare Supplement or Medicare Advantage policy in force? Yes ☐ No ☐

a. If so, with what company, and what plan do you have? _____

b. If so, do you intend to replace your current Medicare Supplement or Medicare Advantage policy with this policy? Yes ☐ No ☐

6. Have you had coverage under any other health insurance within the past 63 days? Yes ☐ No ☐

a. If so, with what company, and what kind of policy?
(For example, an employer, union, or individual plan) _____

b. What are your dates of coverage under the other policy?
(If you are still covered under the other policy, leave "END" blank.)

Start: ___/___/_____

End: ___/___/_____

Applicant Name _____

STATEMENTS

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.*
5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan.*

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

6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). For information on Medicaid eligibility, call your local Social Security office. For questions on Medicare Supplement insurance, call 1-800-MEDICARE (1-800-633-4227).

Questions?

Call us at our Customer Service toll-free number 800-654-9390, call your insurance agent at the number listed on the next page, or visit *www.bcbstx.com*.

Proxy Statement: The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters (300 E Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

Applicant Signature *(optional)*: **X** _____

Print Your Name as You Signed It: _____ Date: ___ ___/___ ___/___ ___ ___ ___

Applicant Name _____

Acknowledgements and Signature

1. I hereby apply for coverage and request a policy to review for the Medicare Supplement policy indicated.
2. I understand that once my first premium payment is received, I will be covered as of the date shown on the Company identification card. Once coverage begins, I understand I have 30 days to return my policy materials and receive a full refund for any premiums paid. Services are covered only when received on or after the effective date of the policy chosen, except in the case of inpatient services, where the admission must occur on or after the effective date to be covered.
3. I hereby declare that the statements and answers on this application, including but not limited to those relating to age and medical history, are true and complete to the best of my knowledge and belief. I agree that the Company, believing them to be true, shall rely and act upon them accordingly. I hereby agree to furnish any additional information, if requested.
4. I understand that the Company has the right to reject my application. If the Company rejects my application, I will be notified in writing. If this application is accepted, it will become part of the insurance policy.
5. I acknowledge that I have read and understand the Statements section regarding Medicare Supplement coverage. If eligible for a Medicare Select Plan, I have also read and understand the statements regarding Medicare Select as described in the Outline of Coverage. WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of a felony.
6. I acknowledge that any agent is acting on my behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an individual policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such individual policy.
7. I acknowledge if I desire additional information regarding any commissions or other compensation paid to the agent by the Company in connection with the issuance of the individual policy, I should contact the agent.
8. I acknowledge that I have received a copy(s) of the Medicare Supplement Buyers Guide.
9. ☐ **Outline of Coverage:** I acknowledge receipt of Outline of Coverage.

SIGNATURE REQUIRED

*Must be signed **in ink** and dated to avoid processing delays. For Power of Attorney and Legal Guardianships, be sure to submit copies of the court documents with the application.*

Applicant X _____ Date: ___ ___/___ ___/___ ___ ___ ___

Agent Information *(If Applicable)*

The following information is to be filled out by an agent, if Applicant is purchasing coverage through an agent.

Please list any other health insurance policies or coverages sold to the applicant which are still in force:

_____

Please list any other health insurance policies or coverages sold to the applicant within the last five (5) years which are no longer in force:

_____

I have reaffirmed that the information supplied on this application is accurate and complete.

Agent Signature: X _____ Date: ___ ___/___ ___/___ ___ ___ ___

Print name: _____ Broker Code: _____

Agency name *(If Applicable)*: _____ Phone: (_____) _____

PLEASE CONTINUE ON PAGE 5 IF YOU ARE NOT NEWLY ELIGIBLE TO ENROLL IN MEDICARE DUE TO AGE OR DISABILITY.

Applicant Name _____

Guaranteed Issue Eligibility

Please mark Yes or No to questions 1-9 with an "X". If you answer "Yes" to any and if you are applying before the 63rd day after your coverage terminated, you are eligible for guaranteed issuance of this Medicare Supplement policy. If you are eligible for guaranteed issuance of this policy, do not complete the Health History/Medical Questions that start on page 6. Proceed to page 8 and sign the Medical Authorization.

Have any of the following events listed below, and on the next page, occurred?

Yes ☐ No ☐ **1.** The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan.

Yes ☐ No ☐ **2.** The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual was enrolled in a Medicare Advantage plan: (A) the certification of the organization or plan has been terminated; or (B) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; (C) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851 (g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area; (D) the individual demonstrates, in accordance with guidelines established by the Secretary, that: (i) the organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or (ii) the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or (E) the individual meets such other exceptional conditions as the Secretary may provide.

Yes ☐ No ☐ **3.** The individual is enrolled with an entity listed in subparagraphs (A)-(D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) of this subsection: (A) an eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost); (B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999; (C) an organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or (D) an organization under a Medicare Select policy; and

Yes ☐ No ☐ **4.** The individual is enrolled under a Medicare supplement policy and the enrollment ceases because: (A) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or of other involuntary termination of coverage or enrollment under the policy; (B) the issuer of the policy substantially violated a material provision of the policy; or (C) the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

Applicant Name _____

Yes ☐ No ☐ **5.** The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under section 1851 (e) of the Social Security Act); or

Yes ☐ No ☐ **6.** The individual, upon first becoming enrolled in Medicare part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan no later than 12 months after the effective date of enrollment.

Yes ☐ No ☐ **7.** The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (c)(4) of this section.

Yes ☐ No ☐ **8.** The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

Yes ☐ No ☐ **9.** The individual meets the following requirements: (A) the individual was enrolled in both the federal Medicare program and the Texas Health Insurance Pool on December 31, 2013; and (B) the individual's Pool coverage terminated on or after December 31 2013.

Health History/Medical Questions

STOP

Note: If you are eligible for Guaranteed Issue or in your Open Enrollment period, you are not required to answer the following health questions. (Continue to page 8.)

Please answer the following health history questions.

1. What is your height? ☐ Ft. ☐ In.

2. What is your weight? ☐ Lbs.

3. When you first became eligible for Medicare, was it either because of disability or end stage renal disease? Yes ☐ No ☐

4. Within the past 3 years, have you been diagnosed, treated, hospitalized or recommended for treatment, including drug therapy, by a physician or any other provider for any of the following:

a. Diabetes with amputation, loss of sight or complications affecting the kidney? Yes ☐ No ☐

b. Organ or tissue transplant (except cornea)? Yes ☐ No ☐

c. Cancer (excluding basal cell or squamous cell cancer of the skin)? Yes ☐ No ☐

d. Leukemia or Hodgkin's disease? Yes ☐ No ☐

e. Stroke, Transient Ischemic Attack (TIA), or mini-stroke? Yes ☐ No ☐

f. Alzheimer's disease, senility, dementia or brain disorder? Yes ☐ No ☐

g. Parkinson's disease? Yes ☐ No ☐

h. Carotid artery disease, heart attack, or heart by-pass surgery or angioplasty? Yes ☐ No ☐

i. Congestive heart failure or heart valve replacement? Yes ☐ No ☐

Applicant Name _____

PART TWO *(continued)*

j. Nephritis or kidney failure? Yes ☐ No ☐

k. Cirrhosis of the liver or Hepatitis C? Yes ☐ No ☐

l. Multiple Sclerosis or neuromuscular disorders? Yes ☐ No ☐

m. Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease)? Yes ☐ No ☐

n. Respiratory or lung disease requiring use of oxygen? Yes ☐ No ☐

o. Alcohol or chemical dependency? Yes ☐ No ☐

5. Within the past 3 years, have you been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or human immunodeficiency virus (HIV) infection? Yes ☐ No ☐

6. Within the past 2 years, have you been advised to have kidney dialysis, joint replacement, or surgery for the heart, arteries or intestines that has not yet been done? Yes ☐ No ☐

7. Within the past 2 years, have you been hospitalized 2 or more times, or have you been confined to a nursing home or other care facility for 14 or more days? Yes ☐ No ☐

8. Are you currently confined, or has confinement been recommended within the next 6 months to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a wheelchair or a home health care agency? Yes ☐ No ☐

9. Do you need or receive help from any other person to perform any of the activities below because of health or physical difficulty? Yes ☐ No ☐

- Taking Medications
- Eating
- Walking
- Bathing
- Dressing
- Toileting
- Moving from place to place in your home
- Getting in and out of bed or chairs

Applicant Name _____

Medical Authorization: I authorize any medical professional, hospital, clinic or other medical or medically related facility, governmental agency or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me, including and without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information.

I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and shall remain valid for 24 months, unless revoked by me in writing, which I may do at any time by sending a written request to the Company. Any revocation will not affect the activities of the Company prior to receipt of the revocation.

SIGNATURE REQUIRED

*Must be signed **in ink** and dated to avoid processing delays.*

Applicant X _____ Date: ___ ___/___ ___/___ ___ ___ ___

Questions?

Call us at our Customer Service toll-free number 800-654-9390, call your insurance agent at the number listed on page 4, or visit *www.bcbstx.com*.

Checklist

- ☐ Have you signed on pages 3, 4, and 8?
- ☐ If you're working with an agent, has the agent signed on page 4 (if applicable)?
- ☐ Have you answered all Health History/Medical Questions on pages 6-7?
- ☐ Have you made sure your requested effective date on page 1 is the 1st through the 28th of the month?

Return to your agent or mail this application to:

Blue Cross and Blue Shield of Texas
P.O. Box 3003
Naperville, IL 60566-7003