



This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Blue Cross and Blue Shield of Texas does not offer those plans shaded in gray below.

Note: A ✓ means 100% of the benefit is paid

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G ¹	K	L	M	N	C	F ¹
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	copays apply ³	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2021 ²					\$6,220 ²	\$3,110 ²				

¹ Plans F and G also have a high deductible option, which require first paying a plan deductible of \$2,370 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

² Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

³ Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that do not result in an inpatient admission.

INNOVATIVE BENEFITS

Information on Routine Eye Exams

You will have access to one routine eye exam each calendar year through a contracted network of providers. A routine eye exam includes:

1. Examination of orbits
2. Test vision acuity
3. Gross visual field testing by confrontation or other means
4. Ocular motility
5. Examination of pupils
6. Measurement of intraocular pressure
7. Ophthalmoscopic examination with pupillary dilation⁴, as indicated, of the following:
 - a. Optic disc(s) and posterior segment
 - b. Macula
 - c. Retinal periphery
 - d. Retinal vessels
 - e. Vitreous

⁴ Pupillary dilation is required for members with diabetes. Additionally, in some cases, the exam may be completed with other instruments because of member limitations. Plan A is not eligible for Routine Eye Exam benefits.

Medicare Supplement Rates effective May 1, 2020 for Area 1

Rates shown are for Texas residents living in ZIP codes that begin with 754-759, 763-769, 778-792, 795-799, and 885.

If you live in a different area, please call the toll-free number on the application and in the information packet.

Plan A is not subject to tobacco or gender rates.

Age 65				
Plan A	\$216.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$180.58	\$164.22	\$199.95	\$181.83
Plan High F¹	\$52.58	\$47.86	\$58.18	\$52.94
Plan G	\$137.47	\$125.02	\$153.93	\$139.99
Plan High G¹	\$52.58	\$47.86	\$58.18	\$52.94
Plan K²	\$88.68	\$80.67	\$98.15	\$89.29
Plan L²	\$124.32	\$113.08	\$137.63	\$125.18
Plan N	\$111.88	\$101.76	\$125.27	\$113.93

Age 66				
Plan A	\$216.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$189.10	\$171.96	\$209.38	\$190.40
Plan High F¹	\$55.04	\$50.10	\$60.90	\$55.42
Plan G	\$144.70	\$131.61	\$161.95	\$147.29
Plan High G¹	\$55.04	\$50.10	\$60.90	\$55.42
Plan K²	\$92.85	\$84.46	\$102.77	\$93.48
Plan L²	\$130.18	\$118.40	\$144.12	\$131.07
Plan N	\$117.76	\$107.11	\$131.79	\$119.86

Age 67				
Plan A	\$248.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$197.61	\$179.70	\$218.81	\$198.97
Plan High F¹	\$57.50	\$52.33	\$63.62	\$57.89
Plan G	\$151.95	\$138.19	\$169.97	\$154.58
Plan High G¹	\$57.50	\$52.33	\$63.62	\$57.89
Plan K²	\$97.01	\$88.25	\$107.38	\$97.68
Plan L²	\$136.03	\$123.72	\$150.60	\$136.97
Plan N	\$123.65	\$112.47	\$138.31	\$125.79

Age 68

Plan A	\$248.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$206.13	\$187.44	\$228.24	\$207.55
Plan High F ¹	\$59.96	\$54.57	\$66.34	\$60.37
Plan G	\$159.19	\$144.77	\$178.00	\$161.87
Plan High G ¹	\$59.96	\$54.57	\$66.34	\$60.37
Plan K ²	\$101.18	\$92.04	\$112.00	\$101.87
Plan L ²	\$141.88	\$129.04	\$157.08	\$142.86
Plan N	\$129.54	\$117.82	\$144.83	\$131.72

Age 69

Plan A	\$248.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$214.64	\$195.19	\$237.67	\$216.12
Plan High F ¹	\$62.42	\$56.80	\$69.07	\$62.85
Plan G	\$166.43	\$151.36	\$186.02	\$169.16
Plan High G ¹	\$62.42	\$56.80	\$69.07	\$62.85
Plan K ²	\$105.34	\$95.82	\$116.61	\$106.07
Plan L ²	\$147.73	\$134.36	\$163.57	\$148.75
Plan N	\$135.43	\$123.17	\$151.35	\$137.65

Age 70

Plan A	\$293.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$223.16	\$202.93	\$247.10	\$224.70
Plan High F ¹	\$64.88	\$59.04	\$71.79	\$65.32
Plan G	\$173.67	\$157.94	\$194.04	\$176.46
Plan High G ¹	\$64.88	\$59.04	\$71.79	\$65.32
Plan K ²	\$109.51	\$99.61	\$121.23	\$110.26
Plan L ²	\$153.59	\$139.68	\$170.05	\$154.65
Plan N	\$141.31	\$128.52	\$157.87	\$143.58

Age 71

Plan A	\$293.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$231.67	\$210.67	\$256.53	\$233.27
Plan High F ¹	\$67.33	\$61.27	\$74.51	\$67.80
Plan G	\$180.91	\$164.53	\$202.06	\$183.75
Plan High G ¹	\$67.33	\$61.27	\$74.51	\$67.80
Plan K ²	\$113.68	\$103.40	\$125.84	\$114.46
Plan L ²	\$159.44	\$145.00	\$176.53	\$160.54
Plan N	\$147.20	\$133.88	\$164.39	\$149.50

Age 72

Plan A	\$293.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$240.19	\$218.41	\$265.97	\$241.84
Plan High F ¹	\$69.79	\$63.51	\$77.24	\$70.27
Plan G	\$188.15	\$171.11	\$210.08	\$191.04
Plan High G ¹	\$69.79	\$63.51	\$77.24	\$70.27
Plan K ²	\$117.84	\$107.19	\$130.46	\$118.65
Plan L ²	\$165.29	\$150.32	\$183.01	\$166.43
Plan N	\$153.09	\$139.23	\$170.91	\$155.43

Age 73

Plan A	\$293.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$248.70	\$226.15	\$275.40	\$250.42
Plan High F ¹	\$72.25	\$65.74	\$79.96	\$72.75
Plan G	\$195.40	\$177.69	\$218.10	\$198.33
Plan High G ¹	\$72.25	\$65.74	\$79.96	\$72.75
Plan K ²	\$122.01	\$110.97	\$135.07	\$122.85
Plan L ²	\$171.15	\$155.64	\$189.50	\$172.33
Plan N	\$158.98	\$144.58	\$177.43	\$161.36

Age 74

Plan A	\$293.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$257.22	\$233.89	\$284.83	\$258.99
Plan High F ¹	\$74.71	\$67.98	\$82.68	\$75.22
Plan G	\$202.64	\$184.28	\$226.13	\$205.63
Plan High G ¹	\$74.71	\$67.98	\$82.68	\$75.22
Plan K ²	\$126.18	\$114.76	\$139.69	\$127.04
Plan L ²	\$177.00	\$160.97	\$195.98	\$178.22
Plan N	\$164.86	\$149.93	\$183.95	\$167.29

Age 75

Plan A	\$327.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$265.73	\$241.63	\$294.26	\$267.57
Plan High F ¹	\$77.17	\$70.21	\$85.40	\$77.70
Plan G	\$209.88	\$190.86	\$234.14	\$212.91
Plan High G ¹	\$77.17	\$70.21	\$85.40	\$77.70
Plan K ²	\$130.34	\$118.55	\$144.30	\$131.24
Plan L ²	\$182.85	\$166.29	\$202.46	\$184.11
Plan N	\$170.75	\$155.28	\$190.48	\$173.22

Age 76

Plan A	\$327.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$274.25	\$249.37	\$303.69	\$276.14
Plan High F ¹	\$79.63	\$72.45	\$88.13	\$80.17
Plan G	\$217.12	\$197.44	\$242.16	\$220.20
Plan High G ¹	\$79.63	\$72.45	\$88.13	\$80.17
Plan K ²	\$134.51	\$122.34	\$148.92	\$135.43
Plan L ²	\$188.71	\$171.61	\$208.94	\$190.01
Plan N	\$176.64	\$160.64	\$197.00	\$179.15

Age 77

Plan A	\$327.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$282.76	\$257.11	\$313.12	\$284.71
Plan High F ¹	\$82.09	\$74.68	\$90.85	\$82.65
Plan G	\$224.36	\$204.03	\$250.18	\$227.50
Plan High G ¹	\$82.09	\$74.68	\$90.85	\$82.65
Plan K ²	\$138.67	\$126.12	\$153.53	\$139.63
Plan L ²	\$194.56	\$176.93	\$215.43	\$195.90
Plan N	\$182.53	\$165.99	\$203.52	\$185.07

Age 78

Plan A	\$327.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$291.28	\$264.85	\$322.55	\$293.29
Plan High F ¹	\$84.54	\$76.91	\$93.57	\$85.12
Plan G	\$231.61	\$210.61	\$258.21	\$234.79
Plan High G ¹	\$84.54	\$76.91	\$93.57	\$85.12
Plan K ²	\$142.84	\$129.91	\$158.14	\$143.82
Plan L ²	\$200.41	\$182.25	\$221.91	\$201.79
Plan N	\$188.41	\$171.34	\$210.04	\$191.00

Age 79

Plan A	\$327.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$299.79	\$272.59	\$331.98	\$301.86
Plan High F ¹	\$87.00	\$79.15	\$96.30	\$87.60
Plan G	\$238.84	\$217.19	\$266.23	\$242.08
Plan High G ¹	\$87.00	\$79.15	\$96.30	\$87.60
Plan K ²	\$147.01	\$133.70	\$162.76	\$148.02
Plan L ²	\$206.26	\$187.57	\$228.39	\$207.69
Plan N	\$194.30	\$176.69	\$216.56	\$196.93

Age 80

Plan A	\$371.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$308.30	\$280.33	\$341.42	\$310.43
Plan High F ¹	\$89.46	\$81.38	\$99.02	\$90.08
Plan G	\$246.09	\$223.78	\$274.25	\$249.37
Plan High G ¹	\$89.46	\$81.38	\$99.02	\$90.08
Plan K ²	\$151.17	\$137.49	\$167.37	\$152.22
Plan L ²	\$212.12	\$192.89	\$234.88	\$213.58
Plan N	\$200.19	\$182.05	\$223.08	\$202.86

Age 81

Plan A	\$371.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$316.82	\$288.08	\$350.85	\$319.01
Plan High F ¹	\$91.92	\$83.62	\$101.74	\$92.55
Plan G	\$253.33	\$230.36	\$282.27	\$256.67
Plan High G ¹	\$91.92	\$83.62	\$101.74	\$92.55
Plan K ²	\$155.34	\$141.27	\$171.99	\$156.41
Plan L ²	\$217.97	\$198.21	\$241.36	\$219.47
Plan N	\$206.08	\$187.40	\$229.60	\$208.79

Age 82

Plan A	\$371.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$325.33	\$295.82	\$360.28	\$327.58
Plan High F ¹	\$94.38	\$85.85	\$104.47	\$95.03
Plan G	\$260.57	\$236.95	\$290.29	\$263.96
Plan High G ¹	\$94.38	\$85.85	\$104.47	\$95.03
Plan K ²	\$159.51	\$145.06	\$176.60	\$160.61
Plan L ²	\$223.82	\$203.53	\$247.84	\$225.37
Plan N	\$211.96	\$192.75	\$236.12	\$214.72

Age 83

Plan A	\$371.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$333.85	\$303.56	\$369.71	\$336.16
Plan High F ¹	\$96.84	\$88.09	\$107.19	\$97.50
Plan G	\$267.82	\$243.53	\$298.31	\$271.25
Plan High G ¹	\$96.84	\$88.09	\$107.19	\$97.50
Plan K ²	\$163.67	\$148.85	\$181.22	\$164.80
Plan L ²	\$229.68	\$208.85	\$254.32	\$231.26
Plan N	\$217.85	\$198.10	\$242.64	\$220.64

Age 84

Plan A	\$371.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$342.36	\$311.30	\$379.14	\$344.73
Plan High F ¹	\$99.29	\$90.32	\$109.91	\$99.98
Plan G	\$275.05	\$250.11	\$306.34	\$278.54
Plan High G ¹	\$99.29	\$90.32	\$109.91	\$99.98
Plan K ²	\$167.84	\$152.64	\$185.83	\$169.00
Plan L ²	\$235.53	\$214.17	\$260.81	\$237.15
Plan N	\$223.74	\$203.46	\$249.17	\$226.57

Age 85

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$350.88	\$319.04	\$388.57	\$353.30
Plan High F ¹	\$101.75	\$92.56	\$112.63	\$102.45
Plan G	\$282.30	\$256.70	\$314.36	\$285.84
Plan High G ¹	\$101.75	\$92.56	\$112.63	\$102.45
Plan K ²	\$172.00	\$156.42	\$190.45	\$173.19
Plan L ²	\$241.38	\$219.49	\$267.29	\$243.05
Plan N	\$229.63	\$208.81	\$255.69	\$232.50

Age 86

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$359.39	\$326.78	\$398.00	\$361.88
Plan High F ¹	\$104.21	\$94.79	\$115.36	\$104.93
Plan G	\$289.54	\$263.28	\$322.37	\$293.13
Plan High G ¹	\$104.21	\$94.79	\$115.36	\$104.93
Plan K ²	\$176.17	\$160.21	\$195.06	\$177.39
Plan L ²	\$247.23	\$224.82	\$273.77	\$248.94
Plan N	\$235.51	\$214.16	\$262.21	\$238.43

Age 87

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$367.91	\$334.52	\$407.43	\$370.45
Plan High F ¹	\$106.67	\$97.03	\$118.08	\$107.40
Plan G	\$296.78	\$269.86	\$330.39	\$300.41
Plan High G ¹	\$106.67	\$97.03	\$118.08	\$107.40
Plan K ²	\$180.34	\$164.00	\$199.68	\$181.58
Plan L ²	\$253.09	\$230.14	\$280.26	\$254.83
Plan N	\$241.40	\$219.51	\$268.73	\$244.36

Age 88

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$376.42	\$342.26	\$416.87	\$379.03
Plan High F ¹	\$109.13	\$99.26	\$120.80	\$109.88
Plan G	\$304.02	\$276.44	\$338.42	\$307.71
Plan High G ¹	\$109.13	\$99.26	\$120.80	\$109.88
Plan K ²	\$184.50	\$167.79	\$204.29	\$185.78
Plan L ²	\$258.94	\$235.46	\$286.74	\$260.73
Plan N	\$247.29	\$224.86	\$275.25	\$250.28

Age 89

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$384.94	\$350.00	\$426.30	\$387.60
Plan High F ¹	\$111.59	\$101.50	\$123.53	\$112.35
Plan G	\$311.26	\$283.02	\$346.44	\$315.00
Plan High G ¹	\$111.59	\$101.50	\$123.53	\$112.35
Plan K ²	\$188.67	\$171.57	\$208.91	\$189.97
Plan L ²	\$264.79	\$240.78	\$293.22	\$266.62
Plan N	\$253.18	\$230.22	\$281.77	\$256.21

Age 90

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$393.45	\$357.74	\$435.73	\$396.17
Plan High F ¹	\$114.04	\$103.73	\$126.25	\$114.83
Plan G	\$318.51	\$289.60	\$354.46	\$322.29
Plan High G ¹	\$114.04	\$103.73	\$126.25	\$114.83
Plan K ²	\$192.84	\$175.36	\$213.52	\$194.17
Plan L ²	\$270.65	\$246.10	\$299.70	\$272.51
Plan N	\$259.06	\$235.57	\$288.29	\$262.14

Age 91

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$401.97	\$365.48	\$445.16	\$404.75
Plan High F ¹	\$116.50	\$105.97	\$128.97	\$117.30
Plan G	\$325.75	\$296.19	\$362.48	\$329.58
Plan High G ¹	\$116.50	\$105.97	\$128.97	\$117.30
Plan K ²	\$197.00	\$179.15	\$218.13	\$198.36
Plan L ²	\$276.50	\$251.42	\$306.19	\$278.41
Plan N	\$264.95	\$240.92	\$294.81	\$268.07

Age 92

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$410.48	\$373.22	\$454.59	\$413.32
Plan High F ¹	\$118.96	\$108.20	\$131.69	\$119.78
Plan G	\$332.99	\$302.77	\$370.50	\$336.88
Plan High G ¹	\$118.96	\$108.20	\$131.69	\$119.78
Plan K ²	\$201.17	\$182.94	\$222.75	\$202.56
Plan L ²	\$282.35	\$256.74	\$312.67	\$284.30
Plan N	\$270.84	\$246.27	\$301.33	\$274.00

Age 93

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$419.00	\$380.97	\$464.02	\$421.89
Plan High F ¹	\$121.42	\$110.44	\$134.42	\$122.26
Plan G	\$340.23	\$309.35	\$378.52	\$344.17
Plan High G ¹	\$121.42	\$110.44	\$134.42	\$122.26
Plan K ²	\$205.33	\$186.73	\$227.36	\$206.75
Plan L ²	\$288.20	\$262.06	\$319.15	\$290.20
Plan N	\$276.73	\$251.63	\$307.86	\$279.93

Age 94

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$427.51	\$388.71	\$473.45	\$430.47
Plan High F ¹	\$123.88	\$112.67	\$137.14	\$124.73
Plan G	\$347.47	\$315.94	\$386.55	\$351.46
Plan High G ¹	\$123.88	\$112.67	\$137.14	\$124.73
Plan K ²	\$209.50	\$190.51	\$231.98	\$210.95
Plan L ²	\$294.06	\$267.38	\$325.63	\$296.09
Plan N	\$282.61	\$256.98	\$314.38	\$285.85

Age 95

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$436.03	\$396.45	\$482.88	\$439.04
Plan High F ¹	\$126.34	\$114.91	\$139.86	\$127.21
Plan G	\$354.72	\$322.52	\$394.57	\$358.75
Plan High G ¹	\$126.34	\$114.91	\$139.86	\$127.21
Plan K ²	\$213.67	\$194.30	\$236.59	\$215.14
Plan L ²	\$299.91	\$272.70	\$332.12	\$301.98
Plan N	\$288.50	\$262.33	\$320.90	\$291.78

Age 96

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$444.54	\$404.19	\$492.32	\$447.62
Plan High F ¹	\$128.79	\$117.14	\$142.59	\$129.68
Plan G	\$361.96	\$329.11	\$402.58	\$366.05
Plan High G ¹	\$128.79	\$117.14	\$142.59	\$129.68
Plan K ²	\$217.83	\$198.09	\$241.21	\$219.34
Plan L ²	\$305.76	\$278.02	\$338.60	\$307.88
Plan N	\$294.39	\$267.68	\$327.42	\$297.71

Age 97

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$453.06	\$411.93	\$501.75	\$456.19
Plan High F ¹	\$131.25	\$119.38	\$145.31	\$132.16
Plan G	\$369.19	\$335.69	\$410.60	\$373.34
Plan High G ¹	\$131.25	\$119.38	\$145.31	\$132.16
Plan K ²	\$222.00	\$201.88	\$245.82	\$223.53
Plan L ²	\$311.62	\$283.34	\$345.08	\$313.77
Plan N	\$300.28	\$273.04	\$333.94	\$303.64

Age 98

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$461.57	\$419.67	\$511.18	\$464.76
Plan High F ¹	\$133.71	\$121.61	\$148.03	\$134.63
Plan G	\$376.44	\$342.27	\$418.63	\$380.63
Plan High G ¹	\$133.71	\$121.61	\$148.03	\$134.63
Plan K ²	\$226.17	\$205.66	\$250.44	\$227.73
Plan L ²	\$317.47	\$288.67	\$351.57	\$319.66
Plan N	\$306.16	\$278.39	\$340.46	\$309.57

Age 99

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$470.09	\$427.41	\$520.61	\$473.34
Plan High F ¹	\$136.17	\$123.85	\$150.76	\$137.11
Plan G	\$383.68	\$348.86	\$426.65	\$387.92
Plan High G ¹	\$136.17	\$123.85	\$150.76	\$137.11
Plan K ²	\$230.33	\$209.45	\$255.05	\$231.92
Plan L ²	\$323.32	\$293.99	\$358.05	\$325.56
Plan N	\$312.05	\$283.74	\$346.98	\$315.50

Age 100+

Plan A	\$398.00			
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
Plan F	\$478.60	\$435.15	\$530.04	\$481.91
Plan High F ¹	\$138.63	\$126.08	\$153.48	\$139.58
Plan G	\$390.93	\$355.44	\$434.67	\$395.21
Plan High G ¹	\$138.63	\$126.08	\$153.48	\$139.58
Plan K ²	\$234.50	\$213.24	\$259.67	\$236.12
Plan L ²	\$329.17	\$299.31	\$364.53	\$331.45
Plan N	\$317.94	\$289.09	\$353.50	\$321.42

You have the option to purchase any of the Medicare Supplement benefit plans shown on the front cover in white as Standard Plans.

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 the state. Any rate increases are subject to approval by the Texas Department of Insurance. We will not change your premium or cancel your policy because of poor health. Premiums change at age 65 and every year thereafter up to age 100. If your premium changes, you will be notified at least 30 days in advance.

- One factor that will determine your premium is your gender. When completing the application, you will need to make a gender selection.
- You may be eligible for a household discount if at least two household members reside in the same household and are enrolled in a Blue Cross and Blue Shield of Texas Medicare Supplement Insurance Plan effective on or after January 1, 2020.
- A Tobacco User is a person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco) occurring on average of four or more times per week that last occurred within the past six months. Tobacco products include but are not limited to: cigarettes, cigars, smokeless tobacco products, electronic cigarettes, dissolvable tobacco products, vaping, etc.

If you meet the definition of a Tobacco User, you may pay a higher premium for your health coverage.

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 your insurance company.

RIGHT TO RETURN YOUR POLICY

If you find that you are not satisfied with your policy, you may return it to **Blue Medicare Supplement, c/o Member Services, P.O. Box 3388, Scranton, PA 18505**. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and will return all of your payments.

POLICY REPLACEMENT

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

NOTICE

This policy may not fully cover all of your medical costs. Neither Blue Cross and Blue Shield of Texas nor its agents are connected with Medicare. This Outline of Coverage does not give you all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & 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.
- Charges for any services and supplies that aren't specifically mentioned in the Policy.

REFUND OF 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 Policy termination date, including a prorated refund for any partial Policy month, if applicable. (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.

Plan A

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

⁵ 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 A Pays	You Pay
Hospitalization⁵ Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,484	\$0	\$1,484 (Part A deductible)
61st through 90th day	All but \$371 a day	\$371 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$742 a day	\$742 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ⁶
Beyond the additional 365 days	\$0	\$0	All costs
Services	Medicare Pays	Plan A Pays	You Pay
Skilled Nursing Facility Care⁵ 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 \$185.50 a day	\$0	Up to \$185.50 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

⁶ 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.

⁷ Once you have been billed \$203 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A 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 \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (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 \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (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 A Pays	You Pay
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

Plan F

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

⁵ 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 F Pays	You Pay
Hospitalization⁵ Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,484	\$1,484 (Part A deductible)	\$0
61st through 90th day	All but \$371 a day	\$371 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$742 a day	\$742 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ⁶
Beyond the additional 365 days	\$0	\$0	All costs
Services	Medicare Pays	Plan F Pays	You Pay
Skilled Nursing Facility Care⁵ 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 \$185.50 a day	Up to \$185.50 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

⁶ 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 F

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

⁷ Once you have been billed \$203 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan F 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 \$203 of Medicare-approved amounts ⁷	\$0	\$203 (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 \$203 of Medicare-approved amounts ⁷	\$0	\$203 (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 F Pays	You Pay
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$203 of Medicare-approved amounts ⁷	\$0	\$203 (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

[†] This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$2,370 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,370. 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.

⁵ 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	After You Pay \$2,370 Deductible [†] , Plan F Pays	In Addition to \$2,370 Deductible [†] , You Pay
Hospitalization⁵ Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,484	\$1,484 (Part A deductible)	\$0
61st through 90th day	All but \$371 a day	\$371 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$742 a day	\$742 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ⁶
Beyond the additional 365 days	\$0	\$0	All costs
Services	Medicare Pays	After You Pay \$2,370 Deductible [†] , Plan F Pays	In Addition to \$2,370 Deductible [†] , You Pay
Skilled Nursing Facility Care⁵ 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 \$185.50 a day	Up to \$185.50 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

⁶ 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

⁷ Once you have been billed \$203 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	After You Pay \$2,370 Deductible [†] , Plan F Pays	In Addition to \$2,370 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 \$203 of Medicare-approved amounts ⁷	\$0	\$203 (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 \$203 of Medicare-approved amounts ⁷	\$0	\$203 (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	After You Pay \$2,370 Deductible [†] , Plan F Pays	In Addition to \$2,370 Deductible [†] , You Pay
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$203 of Medicare-approved amounts ⁷	\$0	\$203 (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

⁵ 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 G Pays	You Pay
Hospitalization⁵ Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,484	\$1,484 (Part A deductible)	\$0
61st through 90th day	All but \$371 a day	\$371 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$742 a day	\$742 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ⁶
Beyond the additional 365 days	\$0	\$0	All costs
Services	Medicare Pays	Plan G Pays	You Pay
Skilled Nursing Facility Care⁵ 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 \$185.50 a day	Up to \$185.50 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

⁶ 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 G

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

⁷ Once you have been billed \$203 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan G 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 \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (unless Part B deductible has been met)
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 \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (unless Part B deductible has been met)
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 G Pays	You Pay
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (unless Part B deductible has been met)
– Remainder of Medicare-approved amounts	80%	20%	\$0

Plan G

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan G 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 G

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

[‡] This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,370 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,370. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

⁵ 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	After You Pay \$2,370 Deductible [‡] , Plan G Pays	In Addition to \$2,370 Deductible [‡] , You Pay
Hospitalization⁵ Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,484	\$1,484 (Part A deductible)	\$0
61st through 90th day	All but \$371 a day	\$371 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$742 a day	\$742 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ⁶
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care⁵ 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 \$185.50 a day	Up to \$185.50 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

⁶ 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 G

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

⁷ Once you have been billed \$203 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	After You Pay \$2,370 Deductible [‡] , Plan G Pays	In Addition to \$2,370 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 \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (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 \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (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	After You Pay \$2,370 Deductible [‡] , Plan G Pays	In Addition to \$2,370 Deductible [‡] , You Pay
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (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

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

⁵ 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.

⁸ You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$6,220 each calendar year. The amounts that count toward your annual limit are noted with an asterisk (*) 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, 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 K Pays	You Pay ⁸
Hospitalization⁵ Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,484	\$742 (50% of Part A deductible)	\$742 (50% of Part A deductible)*
61st through 90th day	All but \$371 a day	\$371 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$742 a day	\$742 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ⁶
Beyond the additional 365 days	\$0	\$0	All costs
Services	Medicare Pays	Plan K Pays	You Pay ⁸
Skilled Nursing Facility Care⁵ 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 \$185.50 a day	50% of Part A coinsurance	50% of Part A coinsurance*
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*

⁶ 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 K

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

⁷ Once you have been billed \$203 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan K Pays	You Pay ⁸
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 \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (Part B deductible)*
Preventive benefits for Medicare-covered services	Generally 80% 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 ² of \$6,220)
Blood			
First 3 pints	\$0	50%	50%*
Next \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (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 K Pays	You Pay ⁸
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (Part B deductible)*
– Remainder of Medicare-approved amounts	80%	10%	10%*

Plan L

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

⁵ 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.

⁹ You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$3,110 each calendar year. The amounts that count toward your annual limit are noted with an asterisk (*) 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, 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 L Pays	You Pay ⁹
Hospitalization⁵ Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,484	\$1,113 (75% of Part A deductible)	\$371 (25% of Part A deductible)*
61st through 90th day	All but \$371 a day	\$371 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$742 a day	\$742 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ⁶
Beyond the additional 365 days	\$0	\$0	All costs
Services	Medicare Pays	Plan L Pays	You Pay ⁹
Skilled Nursing Facility Care⁵ 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 \$185.50 a day	75% of Part A coinsurance	25% of Part A coinsurance*
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*

⁶ 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 L

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

⁷ Once you have been billed \$203 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan L Pays	You Pay ⁹
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 \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (Part B deductible)*
Preventive benefits for Medicare-covered services	Generally 80% 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 ² of \$3,110)
Blood			
First 3 pints	\$0	75%	25%*
Next \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (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 L Pays	You Pay ⁹
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (Part B deductible)*
– Remainder of Medicare-approved amounts	80%	15%	5%*

Plan N

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

⁵ 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 N Pays	You Pay
Hospitalization⁵ Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,484	\$1,484 (Part A deductible)	\$0
61st through 90th day	All but \$371 a day	\$371 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$742 a day	\$742 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ⁶
Beyond the additional 365 days	\$0	\$0	All costs
Services	Medicare Pays	Plan N Pays	You Pay
Skilled Nursing Facility Care⁵ 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 \$185.50 a day	Up to \$185.50 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

⁶ 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 N

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

⁷ Once you have been billed \$203 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan N 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 \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (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 \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	\$0	\$0

Plan N

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan N Pays	You Pay
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$203 of Medicare-approved amounts ⁷	\$0	\$0	\$203 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan N 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

Important Information about Quotes for Medicare Supplement

Quoted prices are based on the criteria specified during your search. This illustration is subject to Blue Cross and Blue Shield of Texas's rating or underwriting and approval, as appropriate, and does not guarantee rates, coverage or effective date. Furthermore, rates are subject to change if any of the information you have provided changes when and if a policy is approved. In addition, Blue Cross and Blue Shield of Texas reserves the right to change rates from time to time. Any rate increases are subject to approval by the Texas Department of Insurance. Not connected with or endorsed by the U.S. Government or Federal Medicare Program.

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