Notice to Buyer

This Policy may not cover all of your medical expenses. The Issuer has the right to increase the Medicare Supplement Premium or change benefits as specified in the **PREMIUMS** section.

No referrals are required to use network providers under this Policy. However, only certain Hospitals are network providers under this policy. Check with your Physician to determine if he or she has admitting privileges at the network Hospital. If he or she does not, you may be required to use another Physician at time of hospitalization or you will be required to pay for all expenses.

Plan F Medicare Select Supplement Insurance Policy

BlueCross BlueShield of Texas

(herein called the Issuer, BCBSTX, We, Us, Our)

Richardson, Collin County, Texas

Has issued this Policy to the Subscriber named on the Identification Card.

This Policy is effective from 12:01 a.m. on the Effective Date shown on the Identification Card and will be continued in effect by the payment of premiums at the rates determined by Us in accordance with the Premiums provision until terminated at 12:00 a.m. on the date described in Termination of Coverage provision.

In Consideration of the payment of Medicare Supplement Premiums as provided in the **PREMIUMS** section hereof, Blue Cross and Blue Shield of Texas agrees to provide benefits to the Subscriber under the terms of this Policy as recited on this and the following pages from the Effective Date of this Policy and for further consecutive monthly periods thereafter unless this Policy is terminated as provided in the **TERMINATION OF COVERAGE** section and **Rescission** provision.

Renewability Provision: This Policy is guaranteed renewable for life by the timely payment of the Medicare Supplement Premium in effect on each Medicare Supplement Premium due date. The Issuer reserves the right to change Medicare Supplement Premiums, but only if the Medicare Supplement Premiums are the same for all policies bearing Form No. UWMSP-SEL(F)-2021 issued to Subscribers in the same age and classification category. Any rate increases are subject to approval by the Texas Department of Insurance. BCBSTX 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.

James Springfield
President
Blue Cross and Blue Shield of Texas

NOTICE OF 30-DAY RIGHT TO EXAMINE POLICY

Within 30 days after its delivery to the Subscriber, this Policy may be surrendered by delivering or mailing it to the Issuer's Administrative Office, branch office, or agent through whom it was purchased. Upon such surrender, any Medicare Supplement Premiums paid will be returned.

Your Identification Card should be carried with you at all times. If you require medical care, show your Identification Card to the Physician or Eligible Hospital.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation
To get information or file a complaint with your insurance company or HMO:

Call: Blue Cross and Blue Shield of Texas
Toll-Free: 1-877-384-9307
Email: BCBSTXComplaints@bcbstx.com
Mail: Blue Medicare Supplement c/o Member Services P. O. Box 4258, Scranton, PA 18505

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Blue Cross and Blue Shield of Texas
Teléfono gratuito: 1-877-384-9307
Correo electrónico: BCBSTXComplaints@bcbstx.com
Dirección postal Blue Medicare Supplement c/o Member Services P. O. Box 4258, Scranton, PA 18505

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

TABLE OF CONTENTS

DEFINITIONS

As Used Herein:

Assignment means in the original Medicare plan, a Physician agrees to accept the Medicare-approved amount as full payment. If you are in the original Medicare plan, it can save you money if your Physician accepts assignment. You still pay your share of the cost of the Physician's visit.

Calendar Year means the period commencing on a January 1 and ending on the next succeeding December 31, inclusive.

Coinsurance means the percentage of the Medicare approved amount that a Subscriber pays after meeting the Medicare Deductible.

Complaint means any dissatisfaction expressed by a Subscriber concerning a Medicare Select issuer or its network providers.

Effective Date means the date that the Subscriber is enrolled on our records for coverage under this Policy.

Eligible Hospital means any Hospital certified within the definition of Section 1861(e) of Medicare, located in the United States, having a medical staff of one or more Physicians and with which the Secretary of the Department of Health and Human Services has contracted for the provision of Medicare benefits.

Eligible Skilled Nursing Facility means a Skilled Nursing Facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services which is approved for payment of Medicare benefits or qualified for approval by Medicare.

Excess Charges means if you are in the original Medicare plan, the difference between a Physician or other health care provider actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

Explanation of Medicare Benefits Form means the Medicare notice of what medical services or supplies were covered, what charges were approved, how much was credited toward the Part A or B deductible, and the amount that Medicare paid.

Foreign Country means any areas not included in the United States.

Grievance means dissatisfaction expressed in writing by a Subscriber insured under a Medicare Select policy with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

Home Health Care means limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Hospice mean a Medicare-certified program that provides care and support to terminally ill patients and their families.

Hospital means an institution primarily engaged in providing inpatient diagnostic and therapeutic services or rehabilitation services. It must:

- be supervised by a licensed Physician or staff of licensed Physicians;
- regularly provide bedside nursing by registered graduate professional nurses; and
- be approved by Medicare.

Rest homes or nursing homes are not considered Hospitals. Neither are institutions mainly offering:

- custodial, educational or rehabilitory care;
- care of the aged; or
- treatment for drug addiction or alcoholism.

Identification Card means the card BCBSTX issues identifying the Subscriber as a BCBSTX member. This card should be

presented with your Medicare card whenever you receive health care services.

Injury means a bodily injury sustained by the Subscriber which is the direct result of an Accident, independent of disease or bodily infirmity or any other cause, and occurs while this Policy is in force.

Lifetime Reserve Days means, in the original Medicare plan, 60 days that Medicare will pay for when you are in a Hospital more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily Coinsurance.

Medicaid means a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary means those services or supplies covered under this Policy and deemed Medically Necessary by Medicare.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Approved Amount means the amount of reimbursement recognized and approved for a particular medical or health care service or procedure by Medicare.

Medicare Benefit Period means the way that original Medicare measures your use of Hospital and Skilled Nursing Facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a Hospital or SNF. The benefit period ends when you haven't gotten any inpatient Hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a Hospital or a SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

Medicare Eligible Expenses means expenses of the kinds covered by Medicare Part A & B, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Hospital Benefit Days means the days during which Part A Medicare Benefits apply to the Part A eligible Hospital expenses incurred by the Subscriber for bed-patient Hospital services. The term shall include any Medicare Part A Lifetime Reserve Days which the Subscriber has not elected to use.

Medicare Part A Benefits means Hospital insurance that pays for inpatient Hospital stays, care in a Skilled Nursing Facility, Hospice care, and some Home Health Care.

Medicare Part B Benefits means Medicare medical insurance that helps pay for Physicians services, outpatient Hospital care, durable medical equipment, and some medical services that are not covered by Part A.

Medicare Select means a Medicare Supplement policy that contains Restricted Network Provisions.

Medicare Skilled Nursing Facility Benefit Days means the days during which Part A Medicare Benefits apply to the Part A Eligible Skilled Nursing Facility Expenses incurred by the Subscriber for inpatient Skilled Nursing Facility services.

Medicare Supplement means a Medigap policy. It is sold by private insurance companies to fill "gaps" in original Medicare plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan N. Medigap policies only work with the original Medicare plan.

Medicare Supplement Benefits means payments for health care services provided to a Subscriber according to the terms of this policy.

DEFINITIONS

Medicare Supplement Premium means the periodic payment to an insurance company or a health care plan for health or prescription drug coverage.

Network Hospital means an Eligible Hospital, which has entered into a written agreement with BCBSTX to provide benefits covered under a Medicare Select policy.

Non-Network Hospital means an Eligible Hospital which has not entered into a written agreement with BCBSTX to provide benefits covered under a Medicare Select policy.

Nurse means a registered graduate professional nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) or any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the Texas Board of Nursing.

Part A Eligible Skilled Nursing Facility Expense means only the Medicare Approved Amount for items of service or supply which are furnished by an Eligible Skilled Nursing Facility on orders of a Physician, used by the Subscriber while an inpatient in such facility, and included in the calculation of Part A Medicare Benefits.

Physician means any types of professionals that are legally authorized by the state to practice, regardless of whether they are Medicare, Medicaid, or Children's health Insurance Program (CHIP) providers.

Restricted Network Provisions means any provision which conditions the payment of benefits, in whole or in part, on the use of Network Hospitals.

Service Area means the geographic area approved by the Texas Department of Insurance as part of the plan of operation or amended plan of operation, within which BCBSTX is authorized to offer a Medicare Select policy.

Sickness means illness or disease of a Subscriber which first manifests itself after the Effective Date of this Policy, and occurs while this Policy is in force.

Skilled Nursing Facility means a properly licensed institution that:

- is approved for payment of Medicare benefits or qualified for approval of Medicare benefits;
- is supervised by a licensed Physician or a staff of licensed Physicians;
- provides 24-hour skilled nursing care and, in most cases, skilled rehabilitative services and other related health services, by, or supervised by, registered graduate Nurses; and
- keeps a daily medical record for each patient.

Rest and retirement homes are not considered Skilled Nursing Facilities. Neither are institutions mainly offering:

- custodial or educational care;
- care of the aged;
- care and treatment of mental illness; or
- treatment for drug addiction or alcoholism.

Skilled Nursing Facility Admission means the period between the time of the Subscriber's entry into an Eligible Skilled Nursing Facility as an inpatient and the time of discontinuance of Skilled Nursing Facility care or discharge by the Physician, whichever first occurs.

Subscriber means the person named on the Identification Card provided for with this Policy.

Supplier means a person, firm or institution furnishing to the Subscriber an item of service or supply for which benefits are provided under this Policy.

Tobacco User means 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 includes but is not limited to: cigarettes, cigars, smokeless tobacco products, electronic cigarettes, dissolvable tobacco products, vaping, etc.

United States means all of the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa and the Northern Mariana Islands.

BENEFITS

Subject to the exclusions, limitations and all other terms and provisions of this Policy, benefits will be provided as specified in the following sections of this section.

BCBSTX has arranged for the administration of the Subscriber's inpatient Hospital benefits through its Medicare Select Insurance program. Under this program, certain Hospitals have entered into a written agreement with BCBSTX to provide services covered under this Policy.

As a Subscriber to the Medicare Select program, you have received a directory of Network Hospitals. There may periodically be changes in the directory. To get the most current directory visit our website or call the Customer Service telephone number shown on the back of Your Identification Card. An applicant needs to live or reside in the Service Area in order to purchase this Policy.

When inpatient services are needed, the Subscriber will need to verify that his Physician has admitting privileges to a Network Hospital.

A. **Care For Which Medicare Part A Benefits Are Payable**

1. **Bed-Patient Hospital Care**

   If a Subscriber receives bed-patient Hospital care and services for which Medicare Part A Benefits are payable, the Subscriber shall be entitled to the benefits described below for care received while covered under this Policy.

   a. Coverage for 100% of the Medicare Part A inpatient Hospital deductible amount during any one Medicare Benefit Period.
      1) If the Subscriber is confined in a Network Hospital the Subscriber will not have to pay 100% of the Part A deductible in effect on the date such Medicare Benefit Period commenced;
      2) If the Subscriber is confined in a Non-Network Hospital, the subscriber will have to pay 100% of the Part A deductible unless:
         a) the confinement results from an admission for Emergency Care or are immediately required for an unforeseen illness, injury, or a condition; and;
         b) it is not reasonable to obtain such services through a Network Hospital.

   b. If the Subscriber is confined for more than 60 Medicare Hospital Benefit Days during any one Medicare Benefit Period, BCBSTX will provide coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare, for each such day in excess of 60 days, if any, up to and including the 150th Medicare Hospital Benefit Day.

   c. If the Subscriber is confined during any one Medicare Benefit Period upon exhaustion of the Medicare Hospital Benefit Days applicable to such Medicare Benefit Period, BCBSTX will provide benefits of 100% of any Medicare Eligible Expenses incurred thereafter during such Medicare Benefit Period if provided by an Eligible Hospital as defined in the **DEFINITIONS** section of this Policy on a Medicare Hospital Benefit Day for an additional period not to exceed 365 days during the Subscriber's lifetime and shall not be available for any service for which a benefit is provided under Section B of this section.

   For the purpose of benefit A.1.a.2)a) above:

   Emergency Care means as bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in: a) placing the patient's health in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

2. **Blood:** BCBSTX will provide benefits for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by Medicare) used by a Subscriber.

3. **Hospice Care:** If the Subscriber is receiving Hospice Care, BCBSTX will provide benefits for the Medicare Coinsurance/copayment for all Part A Medicare eligible expenses and respite care expenses.

4. **Skilled Nursing Facility Care:** If the Subscriber is confined in an Eligible Skilled Nursing Facility for more than 20 Medicare Skilled Nursing Facility Benefit days during any one Medicare Benefit Period, BCBSTX will provide coverage for the actual billed charges up to the Coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital Skilled Nursing Facility care eligible under Medicare Part A.

B. **Care For Which Medicare Part B Benefits Are Payable**

When the Subscriber receives services for which Medicare Part B Benefits are payable, BCBSTX will provide benefits for:

1. All of the Medicare Part B deductible amount per Calendar Year regardless of Hospital confinement;
2. The 20% Coinsurance amount (or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount) for such services; and
3. All the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare Approved Amount; and
4. The reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by Medicare) plus the 20% Coinsurance amount for the remainder of the Medicare Approved Amount for the cost of blood.

C. **Care For Which Medicare Part A Benefits and Medicare Part B Benefits Are Payable**

When the Subscriber receives care for which Medicare Part A Benefits and Medicare Part B Benefits are payable, BCBSTX will provide benefits equal to the Medicare Part B deductible per Calendar Year plus the remainder of the Medicare Approved Amount for durable medical equipment, if any, which is not covered as a Medicare Part A Benefit or a Medicare Part B Benefit solely because it is a 20% Coinsurance amount under the provisions of Medicare.

D. **Emergency Care in a Foreign Country**

If a Subscriber receives Medically Necessary Emergency Care provided by an Eligible Hospital or Physician in a Foreign Country, which Emergency Care:

1. Would have been covered for Medicare Part A Benefits or Medicare Part B Benefits if provided in the United States; and
2. Began during the first 60 consecutive days of each trip outside the United States.

BCBSTX will provide benefits, to the extent not covered by Medicare:

1. At 80% of the billed charges;
2. After satisfaction of a $250 Calendar Year deductible;
3. Up to a $50,000 lifetime maximum benefit**.**

For the purpose of this benefit D:

Emergency Care means care needed immediately because of an injury or an illness of sudden and unexpected onset.

E. **Services and Supplies Provided by Government Facilities:** If a Subscriber receives medical care in a government facility which, in accordance with federal law, is entitled to collect benefits under a Medicare Supplement Policy, such facility shall be entitled to payment for the same Medicare Supplement Benefits specified herein as if the care had been provided in a non-government facility to which Medicare Part A Benefits and Medicare Part B Benefits would be payable.

F. **Extension of Benefits:** Termination of this Policy is without prejudice to any continuous loss that commenced while the Policy was in force, but the extension of benefits beyond the period during which the Policy was in force may be conditioned on the continuous total disability of the Subscriber, limited to the duration of the Policy benefit period, if any, or payment of the maximum benefits.

INNOVATIVE BENEFIT

Routine Eye Exam: The Subscriber 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 testing by confrontation or other means;
4. Ocular motility;
5. Examination of pupils;
6. Measurement of intraocular pressure; and
7. Ophthalmoscopic examination with pupillary dilation*, as indicated, of the following:
    a. Optic disc(s) and posterior segment;
    b. Macula;
    c. Retinal periphery;
    d. Retinal vessels; and
    e. Vitreous.

* Pupillary dilations required for members with diabetes.

* In some cases, exam may be completed with other instrumentation because of Subscriber limitations.

For a list of the contracted network of providers visit our website or call the Customer Service telephone number shown on the back of Your Identification Card.

PAYMENT OF BENEFITS

A. Payment of benefits to a Supplier by BCBSTX for services provided by such Supplier, or to the Subscriber, as We may elect, shall constitute full discharge of all responsibility of BCBSTX to the Subscriber under this Policy.

B. Any benefits under this Policy, payable to the Subscriber, shall, if unpaid at his death may, at the option of BCBSTX, be paid in accordance with the beneficiary designation or the Subscriber's estate.

C. Benefits provided under this Policy are not assignable except to your Supplier.

LIMITATIONS AND EXCLUSIONS

This Policy will not contain limitations and exclusions that are more restrictive than the limitations and exclusions contained in Medicare. The limitations and exclusions include:

A. Charges for any services or supplies to the extent those charges are covered under Medicare.
B. Charges for any services or supplies provided to the Subscriber prior to the Effective Date under the Policy.
C. Charges for any services and supplies that aren't specifically mentioned in the Policy.

PREMIUMS; AGE/RESIDENCE; GRACE PERIOD; CHANGES IN PREMIUMS OR BENEFITS; SUSPENSION OF BENEFITS AND REINSTITUTION OF COVERAGE

Premiums: The Medicare Supplement Premiums applicable to this Policy are determined by the age, tobacco use, gender, and geographic location of the Subscriber, in accordance with the schedules filed with the *Texas Department of Insurance*.

Your first Medicare Supplement Premium is due on the Effective Date of this Policy. Subsequent Medicare Supplement Premiums are due on the first day of the Medicare Supplement Premium period. Premium periods and due dates are shown on your billing statement, subject to the following provisions of the sections.

A. **Age/Residence:** If the Subscriber attains an age or changes his geographic location which results in an adjustment in Medicare Supplement Premium, the Medicare Supplement Premium applicable to this Policy shall automatically be adjusted to the Medicare Supplement Premium applicable to the new age or geographic location effective on the next billing cycle following the Subscriber's birthday or change in residence.

B. **Tobacco Use:** If you meet the definition of a Tobacco User, you may pay a higher Medicare Supplement Premium for your health coverage. If you classify as a Tobacco User at initial enrollment and your status changes to a non-Tobacco User, you can apply to change your status twelve months after discontinued use of all tobacco products.

C. **Gender:** One of the factors that will determine what Medicare Supplement Premium you receive is your gender. As part of your application you will need to make a gender selection.

Household Discount: You may be eligible for a discount if at least two persons reside in the same household and are enrolled in a BCBSTX Medicare Supplement plan effective on or after May 1, 2019.

Grace Period: There is a 31-day grace period allowed from the due date for each Medicare Supplement Premium due after the first Medicare Supplement Premium. During the grace period, this Policy will continue in force, subject to the termination provisions of this Policy.

Changes in Premiums or Benefits: Benefits available under this Policy may be changed automatically to coincide with any changes in the applicable Medicare deductible amount, copayment and Coinsurance percentage factors.
BCBSTX reserves the right to change Medicare Supplement Premiums on no less than 30 days notice to the Subscriber, provided the same change shall apply to all other Plan F Medicare Supplement Policies Form No. UWMSP-SEL(F)-2021. The change shall become effective on the date specified in the notice given by the Issuer. Even though BCBSTX may have accepted Medicare Supplement Premiums for periods subsequent to such date, BCBSTX reserves the right to bill the Subscriber for any difference in Medicare Supplement Premium resulting from the change in Medicare Supplement Premium.

Suspension of Benefits and Reinstitution of Coverage:

1. Benefits and Medicare Supplement Premiums under this Policy shall be suspended at the request of the Subscriber for the period, not to exceed 24 months, in which the Subscriber has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act (Medicaid), but only if the Subscriber notifies BCBSTX within 90 days after the date the Subscriber becomes entitled to such assistance. Upon receipt of timely notice, BCBSTX shall return to the Subscriber that portion of the Medicare Supplement Premium attributable to the period of Medicaid eligibility, subject to adjustment for any claims paid.
2. If the suspension occurs and if the Subscriber loses entitlement to such medical assistance, this Policy shall be automatically reinstituted effective as of the date of termination of the entitlement if the Subscriber provides notice of loss of the entitlement within 90 days after the date of the loss and pays the Medicare Supplement Premium attributable to the period.

PREMIUMS; AGE/RESIDENCE; GRACE PERIOD; CHANGES IN PREMIUMS OR BENEFITS; SUSPENSION OF BENEFITS AND REINSTITUTION OF COVERAGE

3. Benefits and Medicare Supplement Premiums under this Policy shall be suspended, for the period provided by Federal regulation, at the request of the Subscriber if the Subscriber is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan. If the suspension occurs and if the Subscriber loses coverage under the group health plan, this Policy shall be automatically reinstated as of the effective date of the loss of coverage if the Subscriber provides notice of loss of coverage within 90 days after the date of such loss and pays the Medicare Supplement Premium attributable to the period.
4. Reinstitution of coverage:
   a. Shall not provide for any waiting period with respect to treatment of preexisting conditions.
   b. Shall provide for coverage that is substantially equivalent to coverage in effect before the date of the suspension; and
   c. Shall provide for classification of Medicare Supplement Premiums on terms at least as favorable to the Subscriber as the Medicare Supplement Premium classification terms that would have applied to the Subscriber had the coverage not been suspended.

TERMINATION OF COVERAGE

A. This Policy will automatically terminate: (1) at the expiration of the last period for which the Medicare Supplement Premiums shall have been paid to the Issuer, subject to the grace period for payment of renewal Medicare Supplement Premiums; (2) at the death of the Subscriber; or (3) on the date written request for cancellation is made by the Subscriber and received by BCBSTX.

B. Upon termination of this Policy in any manner, including death of the Subscriber, BCBSTX will refund to the Subscriber or his personal representative any portion of the Medicare Supplement Premium previously paid which is applicable to policy Months following the month in which the termination occurred, including a prorated refund for any partial Policy month, if applicable.

GENERAL PROVISIONS

Annual Meeting: Our annual meetings are scheduled to be held at 12:30 p.m. on the last Tuesday in October. They're held at our main office:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601-5099

You may vote in person or by proxy (a person you have selected to represent you).

Change of Beneficiary: The right to change a beneficiary is reserved for the Subscriber, and the consent of the beneficiary or beneficiaries is not required for the surrender or Assignment of this policy, for any change of beneficiary or beneficiaries, or for any other changes in this policy.

Claim Forms: The Issuer will furnish to the Subscriber, upon receipt of a notice of claim, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice, the Subscriber shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

How to File a Claim: Be sure to use your Identification Card when you receive Hospital and medical services. This will speed up claims processing. Your Hospital and Physician service claims will be sent to Medicare for you.

Medicare will send your claims to Blue Cross and Blue Shield of Texas for additional processing.

If you receive services from a Supplier that does not accept Medicare Assignment, and the Supplier will not file claims on your behalf, you can obtain a Medicare claim form online and www.Medicare.gov or from the local Social Security office. Once you receive the Explanation of Medicare Benefits, send a copy to Blue Cross and Blue Shield of Texas within 60 days of receipt.

Conversion: After this Policy has been in force for six months, the Subscriber may apply to convert the coverage to any other Medicare Supplement Insurance Policy the Issuer offers which has comparable or lesser benefits and which does not have a Restricted Network provision. The Policy will be issued on a Guaranteed Issue basis.

A Medicare Supplement Policy is considered to have comparable or lesser benefits unless it provides coverage for one or more of the following benefits not included in this Policy:

- the Medicare Part A Deductible;
- at-home recovery services; or
- Part B Excess Charges.

Conversion of this Policy Due to a Change in the Law: If the Medicare Select Program is substantially modified or becomes invalid because of a change in the law, the Secretary of Health and Human Services may require that all Policies issued under the Medicare Select Program be discontinued. In this event the Policy will terminate. The Issuer will notify the Subscriber in writing of the termination.

The Subscriber may apply to continue the coverage under any other Medicare Supplement Insurance Policy the Issuer offers which has comparable or lesser benefits and which does not have a Restricted Network provision. The Policy will be issued on a Guaranteed Issue basis.

A Medicare Supplement Policy is considered to have comparable or lesser benefits unless it provides coverage for one or more of the following benefits not included in this Policy:

- the Medicare Part A Deductible;
- at-home recovery services; or

- Part B Excess Charges.

Entire Policy; Changes: This Policy includes the endorsements and attached papers, if any, and constitutes the entire Policy. No agent has authority to change this Policy or to waive any of its provisions. No change in this Policy shall be valid unless approved by an executive officer of the Issuer and such approval be endorsed hereon or attached hereto.

Gender: Use herein of a personal pronoun in the masculine gender shall be deemed to include the feminine unless the context clearly indicates the contrary.

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

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

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

In-Hospital Grievances: 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 of the results of a grievance.

Legal Actions: No action at law or in equity shall be brought to recover on this Policy unless brought later than 60 days after the date written proof of loss has been provided in accordance with the requirements of this Policy. An action at law or in equity may not be brought after the expiration of three years after the time written proof of loss is required to be provided.

Medicaid Recipients: Benefits available under this Policy for services or supplies shall not be excluded solely because benefits are paid or payable for such services or supplies under the Medical Assistance Act of 1967, as amended. Further, any such benefits shall be payable to the Texas Department of Human Services to the extent required by the provisions of Chapter 783, Acts of the 66th Legislature, 1979.

Medicare Select: You have the option to purchase any of the Medicare Supplement benefit plans offered by BCBSTX as Standard Plans or as Medicare Select Plans, with the exception of Plan A, High Deductible Plan F, and High Deductible Plan G which are available as **Standard Plans only**.

GENERAL PROVISIONS

Non-Agency: The Subscriber understands that this Policy constitutes a contract solely between the Subscriber and Blue Cross and Blue Shield of Texas. Blue Cross and Blue Shield of Texas is a Division of Health Care Service Corporation (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association (the Association). The license from the Association permits Blue Cross and Blue Shield of Texas through HCSC to use the Blue Cross and Blue Shield Service Marks in the State of Texas. Blue Cross and Blue Shield of Texas is not contracting as the agent of the Association. The Subscriber also understands that he has not entered into this Policy based upon representations by any person other than Blue Cross and Blue Shield of Texas. No person, entity, or organization other than Blue Cross and Blue Shield of Texas shall be held accountable or liable to the Subscriber for any of its obligations created under this Policy. This provision shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Texas other than those obligations created under other provisions of this Policy.

Nonliability for Acts of Suppliers: The Issuer shall not be liable for any act or omission by any person or institution in caring for a Subscriber receiving services for which benefits are provided under this Policy.

Notice: Notice from the Issuer to the Subscriber, as hereinabove provided for, shall mean notice mailed to his address as it appears in the records of the Issuer on the day prior to the date such notice is mailed.

Notice of Claim: The Subscriber shall give or cause to be given written notice to BCBSTX at its Administrative Office in Richardson, Collin County, Texas, within 20 days after he receives any of the services for which benefits are provided herein, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Subscriber to the Issuer at its Administrative Office or to any authorized agent of the Issuer, with information sufficient to identify the Subscriber, constitutes notice to the Issuer.

Other Coverage with BCBSTX: Medicare Supplement coverage on the Subscriber is limited to the one such Medicare Supplement policy issued by BCBSTX and elected by the Subscriber, his beneficiary, authorized individual or his estate, as the case may be, and BCBSTX will return all Medicare Supplement Premiums paid for coverage under all other such policies.

Physical Examinations and Autopsy: BCBSTX, at its own expense, shall have the right and opportunity to examine the person of the Subscriber, when and as often as it may reasonably require during the pendency of the claim, and to make an autopsy in case of death where it is not forbidden by law.

Proof of Loss: Written proof of loss must be furnished to the Administrative Office of BCBSTX at Richardson, Collin County, Texas, by the Subscriber within 90 days after he receives services for which benefits are provided herein. Failure to give notice or furnish proof within the time specified shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to give such notice or furnish such proof and that it was done as soon as was reasonably possible; and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required. Delay in submission of notice or proof due to delay in processing of the Subscriber's benefits under Medicare will be deemed reasonable delay.

Refund of Benefits: If and when it shall be determined that benefits have been paid under this Policy to which the Subscriber was not legally entitled, the Subscriber shall, upon demand, refund such payment to the Issuer.

Reinstatement: If default be made in the Medicare Supplement Premium payments for this Policy, the subsequent acceptance of such payment by the Issuer or any of its duly authorized agents shall be unconditional and shall reinstate the Policy, but only to include benefits for loss from Sickness or Injury originating thereafter. In all other respects, the Subscriber and the Issuer shall have the same rights hereunder as they had under the Policy immediately before the due date of the defaulted Medicare Supplement Premiums, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any payments accepted in connection with a reinstatement shall be applied to a period for which Medicare Supplement Premiums have not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

GENERAL PROVISIONS

Rescission: Any omission of a material fact, or fraudulent statements, or intentional misrepresentation of a material fact on the Subscriber's application will result in the voiding (rescinding) of the Subscriber's coverage back to the Effective Date of coverage. In the event of such voiding of the coverage, the Issuer may deduct from the Medicare Supplement Premium refund any amounts made in benefit payments during this period. The Subscriber may be liable for any benefit payment amount greater than the total amount of Medicare Supplement Premiums paid during the period for which the voiding of the coverage is effective.

Subrogation: The Issuer shall be subrogated to all rights of recovery which the Subscriber may acquire against any other person or organization for negligence or any willful act resulting in Sickness or Injury for which benefits are provided under this Policy, but only to the extent of the benefits so provided. The Subscriber, by receiving benefits under this Policy in such case, shall be deemed to have assigned such rights of recovery to the Issuer and to have agreed to do whatever may be reasonably necessary to secure the recovery, including execution of all appropriate papers.

Time Limit on Certain Defenses:

1. After two years from the Effective Date of this Policy, no misstatements, except fraudulent misstatements, made in the application herefor shall be used to void the Policy or to deny a claim for services provided after the expiration of such two year period.
2. No claim for loss incurred or disability commencing after the Effective Date of this Policy shall be reduced or denied on the ground that a disease or physical condition had existed prior to the Effective Date of this Policy.

Time of Payment of Claims: Benefits payable under this Policy for any loss will be paid immediately upon receipt of due written proof of such loss. Medicare will send your claims to BCBSTX for additional processing.

An Amendment

To be attached to and made a part of your Blue Cross and Blue Shield of Texas Medicare Supplement Insurance Policy.

Your Policy and any Amendments attached to the Policy are amended as follows:

The Premiums provision under the PREMIUMS; AGE/RESIDENCE; GRACE PERIOD; CHANGES IN PREMIUMS OR BENEFITS; SUSPENSION OF BENEFITS AND REINSTITUTION OF COVERAGE section of the Policy is amended by deleting the Premium Discount provision and replacing it with the following provision:

Premium Discounts: A BCBSTX Medicare Supplement premium discount may be available. The available premium discounts and eligibility criteria are described below. If you are eligible for a discount, the discount will be applied to your next bill and remain in effect as long as you are enrolled in your BCBSTX Medicare Supplement plan.

Discounts cannot be combined; only one type of discount per member permitted.

Household Discount: You reside with a spouse or common law/domestic partner OR have resided with as many as three adults age 60 or older for the last 12 months. Applies to BCBSTX Medicare Supplement policies issued with an effective date on or after January 1, 2020. A BCBSTX Medicare Supplement premium discount of 10% may be available.

Continue with Blue Discount:

New members whose BCBSTX Medicare Supplement policies have an effective date on or after May 1, 2022: You had commercial group or individual health insurance coverage with a Blue Cross and Blue Shield Plan issued in Illinois, Montana, New Mexico, Oklahoma or Texas. and that coverage was within one year of your BCBSTX Medicare Supplement policy becoming effective. Applies to BCBSTX Medicare Supplement policies issued with an effective date on or after May 1, 2022. A BCBSTX Medicare Supplement premium discount of 7% may be available.

Current members whose BCBSTX Medicare Supplement policies have an effective date on or after January 1, 2020: You had commercial group or individual health insurance coverage with a Blue Cross and Blue Shield Plan issued in Illinois, Montana, New Mexico, Oklahoma or Texas. and that coverage was within one year of your BCBSTX Medicare Supplement policy becoming effective. Applies to BCBSTX Medicare Supplement policies issued with an effective date on or after May 1, 2022. A BCBSTX Medicare Supplement premium discount of 7% may be available.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Policy to which this amendment is attached will remain in full force and effect.

Blue Cross and Blue Shield of Texas (BCBSTX)

By: 

James Springfield
President