



BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.®

Let us help you make
the most of your
**Medicare
Choices
in Texas**



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Give yourself an "A".

You're off to a smart start. You asked us – **Blue Cross and Blue Shield of Texas (BCBSTX), a Division of Health Care Service Corporation¹** – for more information about Medicare Supplement insurance plans. That was a good beginning because Medicare Supplement insurance plans can be a complicated subject. And many thousands of dollars – your dollars – could potentially be at stake. So you want to be sure you get it right. To help you, we've briefly addressed several related topics you might find useful.

- › A short review of the Medicare program
- › What you should know about Medicare Supplement insurance plans
- › Why you can rely on BCBSTX for service and know-how
- › How a Medicare Select insurance plan can help you save more money
- › Discounts on health care products and services through our BlueExtras program
- › What our subscribers say about us
- › Answers to your questions

Call your BCBSTX authorized agent.

If you are turning age 65, your acceptance in a Medicare Supplement insurance plan is guaranteed if: (1) You are a Texas resident, age 65 or older, have Medicare Part A and are within the six months following your enrollment for Medicare Part B; (2) You are a Texas resident, under age 65, have Medicare Part A and are within the six months following your enrollment for Medicare Part B (For Plan A only); or (3) You are a Texas resident turning age 65, were previously enrolled in Medicare Parts A and B, and apply within six months of turning age 65.

¹Not connected with or endorsed by the U.S. Government or the Federal Medicare Program.

Medicare basics

This booklet is about Medicare Supplement (sometimes referred to as Medigap) insurance plans. But to understand those policies, you need to know how the Medicare system works. If you already know how Medicare works, you can skip this section.

Who is Medicare for?

Medicare is health insurance for people age 65 or older, individuals under 65 with certain disabilities, and any age with End-Stage Renal Disease (ESRD). To see if you qualify for Medicare, contact Centers for Medicare and Medicaid Services: 1-800-633-4227 or www.medicare.gov

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services

**7500 Security Boulevard
Baltimore, Maryland 21244
1-877-696-6775**

Original Medicare covers many health care services and supplies, but there are several costs (or gaps) it doesn't cover.

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We've earned high marks too.

It's also important for you to trust us. But you may know little about us and even less about how well we treat our subscribers. That's where our subscriber satisfaction surveys can help you see what subscribers say about us.

According to our latest subscriber satisfaction surveys, 94² percent of our BCBSTX subscribers would recommend us to others. At a time when good service seems a relic of some distant era, that 94² percent underscores just how responsive our service is. And there's more:

- 96² percent of Texas subscribers rate the total value we provide as good to excellent
- 93² percent say they are loyal to BCBSTX
- And, overall, 95² percent of our subscribers are satisfied with us.

These high marks for service excellence are earned every time we interact with our customers. Yes, price is important. But it's the sum total of our whole service package and concern for the community that our subscribers appreciate.

Of course, the chance to save lots of money doesn't hurt either. . .

You could make your wallet up to \$54,902 heavier.³

Protect yourself against gaps in Medicare coverage and you could save \$54,902 in uncovered medical expense. The reason? Medicare was never meant to pay all of your hospital and medical expenses. Those coverage gaps can cost you more than you might think. Let's say, for example, you rely on Medicare to cover all your medical expenses. You may pay up to \$54,902 to cover the claims that Medicare won't. And that's just for a single year.

²Source: Over 65, BCBSTX subscriber loyalty survey, June 2010, 12-month rolling average.

³Based on an unusual or unique claim.

continued from page 1

Medicare helps cover specific services, as long as you meet certain conditions.

Medicare Part A: Hospital Insurance.

- Helps pay for inpatient care in hospitals
- Helps cover skilled nursing facilities, hospice, and home health care

Medicare Part B: Medical Insurance

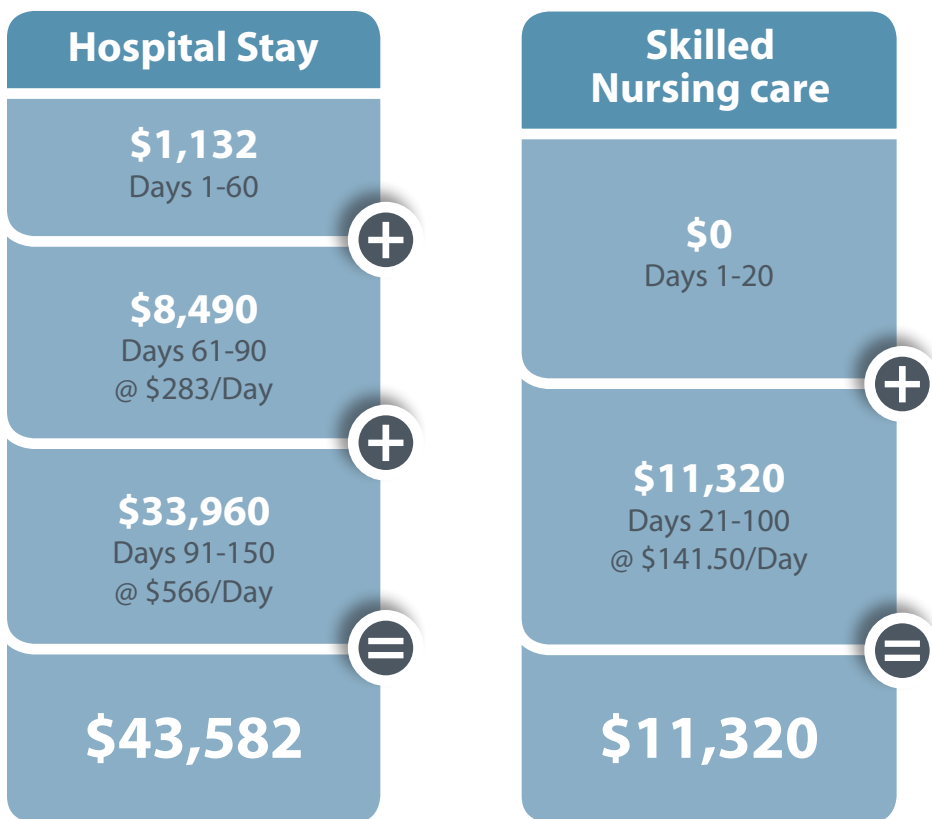
- Helps cover doctors' services and outpatient care
- Helps pay for some preventive services to help maintain your health and to prevent certain illnesses from getting worse

Medicare Part D: Medicare Prescription Drug Coverage

- Helps cover the cost of prescription drugs
- May help lower your prescription drug costs and helps protect against future cost increases

The chart below shows what happens when you have a serious illness or injury without a Medicare Supplement insurance policy to protect you.

Cost savings chart



Without a Medicare Supplement Insurance Plan, your out-of-pocket costs for Part A alone could be...

\$54,902

continued from page 2

Medicare costs: Part A and Part B

Most folks pay no monthly premium for Medicare Part A, usually because someone in their family previously paid Medicare taxes while working. Part B premiums must be paid monthly, may change annually, and can be deducted from your Social Security check, if you wish.

The outpatient deductible for Medicare Part B beneficiaries in 2011 is \$162 per calendar year. Medicare Part A deductible is \$1,132.

What you need to know

- Generally, you must have Medicare Part A and Part B to buy a Medicare Supplement insurance plan policy.
- You pay a premium for your Medicare Supplement insurance policy to your insurance company – in this case, BCBSTX – in addition to the monthly Part B premium that you pay to Medicare.

continued on page 4



Nothing falls through the cracks.

Act now to avoid the unplanned cost of an uncovered medical expense. BCBSTX can help. Let us show you four Medicare Supplement insurance plans that may fit your needs and budget: Plans F, High Deductible F, G, and N.*

All of these plans offer you:

- **A name recognized by doctors and specialists everywhere**
- **Peace of mind knowing that your coverage is with a financially stable and recognized leader serving Texas for more than 80 years**
- **Cost-effective coverage for many Medicare-eligible expenses, such as:**
 - Hospital Care
 - Office Visits/Physician Services
 - Outpatient X-Rays and Lab Tests
 - Physical, Radiation and Speech Therapy
 - Ambulance Service

What these plans cover.

Medicare Supplement insurance plans cover these basic benefits:

- Part A hospitalization coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Part B medical coinsurance (generally 20 percent of Medicare approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- The first three pints of blood each year.
- Hospice Part A coinsurance.

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- A Medicare Supplement insurance policy covers one person. If you and your spouse both want coverage, you will need to buy separate policies.
- Any Medicare Supplement insurance policy is guaranteed renewable. Rates are subject to change.
- In the past, some Medicare Supplement insurance policies covered prescription drugs. Now, no new policies are allowed to include prescription drug coverage. If you want prescription drug coverage, you must enroll in a Medicare Prescription Drug Plan (Part D) offered by private companies, including BCBSTX, approved by Medicare.

Learn more.

This booklet is meant only to provide a brief guide. To get more information and assistance, please call us toll-free 1-888-731-0415 or visit our Web site: www.bcbstx.com

*We also offer a basic option Plan A, as well as Plan K and Plan L.

Multiply your savings with our Medicare Select option⁴.

With Medicare Select, you get the same benefits as our standard Medicare Supplement insurance plans *and* you reduce your costs. To save on premiums you simply agree to use one of the Medicare Select network hospitals for non-emergency services.⁴ Emergency care, however, is covered at any hospital. And, as with all of our Medicare Supplement insurance plans, BCBSTX is recognized by doctors and specialists everywhere.

For the most up-to-date listing of Texas Medicare Select network hospitals, please call us toll-free 1-888-731-0415 or visit our Web site: www.bcbstx.com/over65/medicaresupplement.

If you do use a non-network hospital for a non-emergency admission, you must pay the \$1,132 Part A deductible yourself. **Also, to be eligible, you must live within 30 miles of a network Medicare Select hospital.**



The future is
in your hands.

⁴Only 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 the time of hospitalization, or if you still use a non-network hospital, you must pay the Part A deductible and any non-covered charges.



Medicare (Part A) - Hospital Services Per Benefit Period

A benefit period begins on the first day you receive inpatient services 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.

Service: **HOSPITALIZATION***. Semiprivate room and board, general nursing, and miscellaneous services and supplies.

	Medicare Pays	Plan Pays	You Pay	Plan
First 60 days	All except \$1,132	\$1,132** (Part A Deductible)	\$0	F, F-HD ⁵ , G, N
61st through 90th day	All except \$283 per day	\$283 per day	\$0	F, F-HD, G, N
91st day and after: while using 60 lifetime reserve days	All except \$566 per day	\$566 per day	\$0	F, F-HD, G, N
Once lifetime reserve days are used:				F, F-HD, G, N
Additional 365 days;	\$0	100% of Medicare Eligible Expenses	\$0 ⁶	
Beyond the additional 365 days	\$0	\$0	All costs	

*Hospital does not include a nursing home, convalescent home, extended care facility or psychiatric hospital.

**Please understand, if you choose the Medicare Select option, you must use a Medicare Select network hospital for all non-emergency admissions to receive coverage for the \$1,132 Part A hospital deductible.

In an emergency, the \$1,132 deductible is covered at any hospital from which you receive care.

⁵High deductible Plan F (F-HD) pays the same or offers the same benefits as Plan F after you have paid a calendar year \$2,000 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

In total we sell Medicare Supplement insurance plans A, F, F-HD, G, K, L, and N, as well as Medicare Select versions of F, G, K, L, and N. Policy numbers are: UWMSP(A)-2010, UWMSP(F)-2010, UWMSP(F-HD)-2010, UWMSP(G)-2010, UWMSP(K)-2010, UWMSP(L)-2010, UWMSP(N)-2010, UWMSP-SEL(F)-2010, UWMSP-SEL(G)-2010, UWMSP-SEL(K)-2010, UWMSP-SEL(L)-2010, UWMSP-SEL(N)-2010.

⁶NOTICE: 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 billed charges and the amount Medicare would have paid.

Medicare (Part B) - Medical Services Per Calendar Year

Service: **MEDICAL EXPENSES** include expenses in or out of the Hospital and Outpatient Treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, and durable medical equipment.

	Medicare Pays	Plan Pays	You Pay	Plan
First \$162 of Medicare-approved amounts*	\$0	\$162 (Part B Deductible)	\$0	F, F-HD**
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B Deductible)	G, N
Remainder of Medicare-approved amounts*	Generally 80%	Generally 20%	\$0	F, F-HD, G
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.	N
Part B ⁷ Excess Charges (above Medicare-approved amounts)	\$0	100%	\$0	F, F-HD, G
Part B ⁷ Excess Charges (above Medicare-approved amounts)	\$0	\$0	All costs	N

*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk) your Part B deductible will have been met for the calendar year.

**F-HD refers to High Deductible Plan F.

⁷Part B Excess: by law no physician may charge more than 115% of the Medicare-approved amounts.



Blue Access[®] for Members

Would you like to know when your medical claims are paid and the payment amounts?

Blue Access for Members (BAM), the secure member portal from BCBSTX, can help. You will be able to get immediate online access to health and wellness information and:

- › Check the status of a claim and your claims history
- › View and print an Explanation of Benefits (EOB) for a claim
- › Locate a doctor, specialist or hospital
- › Select an option to stop receiving EOBs in the mail
- › Sign up to receive claim status e-mail alerts
- › Request a new or replacement member ID card or print a temporary member ID card



Protecting
yourself is easier
than you think.

If that's not enough: BlueExtrasSM.

BCBSTX encourages Medicare Supplement subscribers to experience healthy lifestyles through our BlueExtras Discount Program.⁸ Through BlueExtras, BCBSTX subscribers are eligible to save money on value-added health care products and services that can enhance subscriber health and well-being. Simply show your BCBSTX ID card to a BlueExtras provider to receive your discount. There are no claims to file, no referrals or pre-authorization – it's just another advantage of being a BCBSTX subscriber. And best of all, your BlueExtras discount program adds nothing to the cost of your Medicare Supplement insurance coverage!

The BlueExtras program includes discounts on:

- Complementary Alternative Medicine (CAM): acupuncture, vitamins/herbal supplements, chiropractic, health and wellness-related magazines, and more.
- Weight Management programs at Seattle Sutton's Healthy Eating® or Jenny Craig®
- Vision products and services: eyewear, contact lenses and laser correction surgery.
- Hearing products and services: hearing aids and exams.
- And more.

Fitness Program

Introducing: A fitness program⁹ that fits your lifestyle!

The Fitness Program is available to our BCBSTX subscribers. The program opens the door to a network of fitness centers with locations that are close to home or work, near friends and family and available while you are traveling. It's never been more convenient or affordable to start your own personal campaign to get and stay in shape.

Here's what The Fitness Program will offer you:

- Virtually unlimited access to nation wide network of popular fitness clubs including Bally's Total Fitness, 24-Hour Fitness, and participating YMCAs.
- Flexible membership, no long-term contracts for a one-time enrollment fee of just \$29, then \$29 a month (plus applicable taxes).
- Easy online registration once you become a subscriber of our Medicare Supplement insurance plan.

⁸BlueExtras is a value-added discount program available to BCBSTX Medicare Supplement subscribers. The products and services available through BlueExtras are not part of the Medicare Supplement insurance plan being advertised in this information packet. The Blue Extras discount health care program is not insurance. The value-added products and services may be discontinued or changed at any time and may be subject to geographic availability.

⁹The Fitness Program is not part of the Medicare Supplement insurance plan being advertised in this information packet. The Fitness Program may be discontinued or changed at any time and may be subject to geographic availability. Subscribers are responsible for all fees, dues and other charges related to The Fitness Program. Refer to the program terms and conditions for further details.



Ten more reasons to join us.

We're not just about cost – though we're priced very competitively. We also offer you more for your money. Our goal is to make it easy for you to choose BCBSTX.

- 1 Medicare Supplement insurance plans could cover more than \$54,900 of uncovered Medicare expenses
- 2 Virtually hassle-free claims processing
- 3 A name recognized by doctors and specialists everywhere
- 4 Reliable coverage from a respected industry leader
- 5 Helpful individual service
- 6 Coverage when you travel abroad¹⁰
- 7 Online information on claims, benefits, and tools
- 8 Providing more than 80 years of experience, know-how, and service to Texas residents
- 9 BlueExtras Discount Program that encourages subscribers to experience healthy lifestyles
- 10 Easy, online enrollment is available



You're protecting your loved ones too.

¹⁰This is emergency coverage when care is needed immediately because of an injury or illness of sudden and unexpected onset, which care begins during the first 60 days of travel outside the USA. Foreign travel is not covered under Plan A, Plan K or Plan L.

Any questions?

Please call us. But in the meantime, here are some questions we thought you might ask.

Q. Can I go to any doctor or specialist I choose?

A. As a Medicare Supplement insurance plan subscriber, you're free to go to any doctor or specialist who accepts Medicare. There are no networks and no restrictions. The coverage will be recognized across the country.

Q. Am I covered out of state?

A. Absolutely! When you carry your ID card, coverage goes with you. The ID card is recognized and accepted by doctors and hospitals across the country. Just present the ID card to a provider. If charges are covered by Medicare and Medicare approves the charges, so will we!

Q. I want to save on my premiums with your Medical Select option, but I'm not sure how it works. Can you tell me?

A. By choosing the Medicare Select option, you save on premiums over our Standard option by simply agreeing to use any of the Medicare Select network hospitals for all non-emergency admissions. If you do not use one of these hospitals for a non-emergency, you agree to pay the \$1,132 Part A hospital deductible and any non-covered charges. In an emergency, the \$1,132 hospital deductible is covered at any hospital from which you receive care. **To qualify for a Medicare Select option, you must live within 30 miles of one of our Medicare Select network hospitals.**

Q. What are my payment options?

A. You have several payment options available to you. If you have your bill mailed to you, you can choose these payment options: monthly, bi-monthly, quarterly, semi-annually, or annually. You may also have your premium payment directly withdrawn from your bank account monthly by enrolling in our convenient EZ BlueSM Payment Option. It's an easy way to save time and prevent errors. Credit card payments are not accepted at this time.



Q. What happens if I apply for BCBSTX coverage and then I change my mind?

A. When you apply to BCBSTX, the policy is yours to examine without cost or obligation. You don't have to send any money! If coverage is extended, you'll receive your policy package in the mail to examine. When you are satisfied, be sure to pay the first premium to activate your coverage.

If you are not satisfied for any reason, you can follow these simple steps: Within 30 days after its delivery to you, this policy may be surrendered by delivering or mailing it to the BCBSTX (the Insurer) Administrative Office, branch office, or agent through whom it was purchased. Upon such surrender, any premiums paid – less any claims paid – will be returned.

Q. What happens if I'm eligible for Medicaid?

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

Q. Can my coverage be cancelled or my premiums change?

A. As long as you pay your premium on time, your coverage will not be cancelled because of changes in your health. Premium rates change at ages 67, 70, 75, 80, and 85. Your premium rates may also change if you move from your primary place of residence or if there is a rate change for everyone in your class of coverage.

Q. Does Medicare Supplement insurance cover prescriptions drugs?

A. No, Medicare Supplement insurance does not include prescription drug coverage. Medicare introduced Medicare Prescription Drug Coverage (commonly referred to as Part D), to administer prescription drug benefits. You must enroll in Part D independently of Medicare Supplement insurance. Like Medicare Supplement insurance, Part D is administered by private insurers. BCBSTX offers Part D prescription drug coverage. Contact us for more information.

Q. How do I know if there is an open enrollment opportunity and if I am eligible for Guaranteed Acceptance?

A. Please refer to Section F on the enclosed application. If you answer "yes" to any of the questions in this section, you are eligible for coverage on a Guaranteed Acceptance basis and do not have to answer any of the Health History/Medical questions in Part Two. If you are not eligible for coverage on a Guaranteed Acceptance basis, you must answer all Health History/Medical questions in Part Two to be considered for coverage. If you have any additional questions regarding open enrollment, please call your BCBSTX authorized agent.

Close the \$54,902 Medicare coverage gap today.

Take these easy steps to help protect yourself against uncovered medical costs.

- › **Use the coverage chart included** to familiarize yourself with our Medicare Supplement insurance plans. Keep in mind that all plans feature a basic benefits package that covers a significant portion of the Medicare gap.
- › **Note the differences between our plans.** Some Medicare Supplement insurance plans feature additional coverage options. To help lower cost, some other plans offer less comprehensive benefits or higher cost sharing.
- › **Consider your situation,** compare plan costs, and apply for the plan that best fits your needs.

We want you to be 100% satisfied, and we work hard – very hard – to reach that goal. Maybe that's why our subscribers give us such high "Value" ratings – you really do get more for your money from BCBSTX. Remember, to apply you must be a Texas resident and generally be covered by Medicare Parts A and Parts B. We look forward to you being our next satisfied subscriber!

Someday,
you'll thank yourself.





Important Enrollment Information:

[Outline of Coverage](#)

[Medicare Supplement Application](#)

[Business Reply Envelope](#)



**Blue Cross Blue Shield
of Texas**

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

**This chart shows the benefits included in each of the standard Medicare supplement plans sold on or after June 1, 2010.
Every company must make Plan "A" available. Some plans may not be available in Texas.**

BASIC BENEFITS:

- Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- Blood – First three pints of blood each year.
- Hospice – Part A coinsurance.

A	B	C	D	F*	G	K	L	M	N
Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance*	Basic, including 100% Part B Coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%.	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%.	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance, except up to \$20 copayment for office visit, and up to \$50 Copayment for ER
	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
	Part B Deductible	Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit \$4,640; paid at 100% after limit reached	Out-of-pocket limit \$2,320; paid at 100% after limit reached		

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

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

2011 MEDICARE SUPPLEMENT MONTHLY RATES BY AREA

3-Digit Zips for Area 1:

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

Area 1 Rates By Plan:

AGES	OPTION	A	F	F*	G	K	L	N
65-66	Standard	\$193.00	\$137.00	\$45.00	\$123.00	\$69.00	\$97.00	\$96.00
	Medicare Select	N/A	\$119.00	N/A	\$106.00	\$66.00	\$92.00	\$83.00
67-69	Standard	\$223.00	\$155.00	\$50.00	\$140.00	\$79.00	\$113.00	\$108.00
	Medicare Select	N/A	\$138.00	N/A	\$124.00	\$78.00	\$109.00	\$96.00
70-74	Standard	\$262.00	\$183.00	\$59.00	\$165.00	\$93.00	\$132.00	\$128.00
	Medicare Select	N/A	\$152.00	N/A	\$138.00	\$88.00	\$120.00	\$106.00
75-79	Standard	\$292.00	\$205.00	\$67.00	\$185.00	\$104.00	\$148.00	\$144.00
	Medicare Select	N/A	\$165.00	N/A	\$148.00	\$91.00	\$127.00	\$116.00
80-84	Standard	\$331.00	\$232.00	\$75.00	\$209.00	\$120.00	\$167.00	\$163.00
	Medicare Select	N/A	\$182.00	N/A	\$163.00	\$99.00	\$138.00	\$128.00
85 +	Standard	\$357.00	\$251.00	\$81.00	\$226.00	\$128.00	\$181.00	\$176.00
	Medicare Select	N/A	\$197.00	N/A	\$176.00	\$108.00	\$148.00	\$138.00

3-Digit Zips for Area 2:

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

Area 2 Rates By Plan:

AGES	OPTION	A	F	F*	G	K	L	N
65-66	Standard	\$211.00	\$149.00	\$48.00	\$134.00	\$77.00	\$108.00	\$104.00
	Medicare Select	N/A	\$129.00	N/A	\$118.00	\$73.00	\$101.00	\$91.00
67-69	Standard	\$245.00	\$172.00	\$56.00	\$155.00	\$89.00	\$124.00	\$121.00
	Medicare Select	N/A	\$152.00	N/A	\$138.00	\$88.00	\$120.00	\$106.00
70-74	Standard	\$290.00	\$202.00	\$66.00	\$182.00	\$102.00	\$145.00	\$142.00
	Medicare Select	N/A	\$168.00	N/A	\$152.00	\$94.00	\$132.00	\$118.00
75-79	Standard	\$321.00	\$229.00	\$75.00	\$205.00	\$118.00	\$164.00	\$160.00
	Medicare Select	N/A	\$184.00	N/A	\$165.00	\$102.00	\$140.00	\$129.00
80-84	Standard	\$369.00	\$257.00	\$83.00	\$231.00	\$130.00	\$185.00	\$180.00
	Medicare Select	N/A	\$200.00	N/A	\$181.00	\$110.00	\$152.00	\$140.00
85 +	Standard	\$393.00	\$277.00	\$90.00	\$250.00	\$142.00	\$201.00	\$194.00
	Medicare Select	N/A	\$217.00	N/A	\$196.00	\$120.00	\$165.00	\$152.00

2011 MEDICARE SUPPLEMENT MONTHLY RATES BY AREA

3-Digit Zips for Area 3:

out-of-state

Area 3 Rates By Plan:

AGES	OPTION	A	F	F*	G	K	L	N
65-66	Standard	\$234.00	\$167.00	\$54.00	\$150.00	\$85.00	\$120.00	\$117.00
	Medicare Select	N/A	\$144.00	N/A	\$129.00	\$80.00	\$113.00	\$101.00
67-69	Standard	\$269.00	\$190.00	\$61.00	\$170.00	\$96.00	\$137.00	\$132.00
	Medicare Select	N/A	\$167.00	N/A	\$150.00	\$95.00	\$133.00	\$117.00
70-74	Standard	\$316.00	\$221.00	\$72.00	\$200.00	\$114.00	\$159.00	\$154.00
	Medicare Select	N/A	\$185.00	N/A	\$167.00	\$106.00	\$144.00	\$130.00
75-79	Standard	\$358.00	\$250.00	\$81.00	\$225.00	\$127.00	\$181.00	\$175.00
	Medicare Select	N/A	\$201.00	N/A	\$181.00	\$110.00	\$154.00	\$141.00
80-84	Standard	\$403.00	\$283.00	\$92.00	\$256.00	\$145.00	\$204.00	\$198.00
	Medicare Select	N/A	\$221.00	N/A	\$200.00	\$123.00	\$168.00	\$154.00
85 +	Standard	\$434.00	\$306.00	\$100.00	\$276.00	\$156.00	\$220.00	\$215.00
	Medicare Select	N/A	\$240.00	N/A	\$216.00	\$133.00	\$181.00	\$168.00

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

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

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and Blue Cross and Blue Shield of Texas.

RIGHT TO RETURN YOUR POLICY

If you find that you are not satisfied with your policy, you may return it to Blue Cross and Blue Shield of Texas, P.O. Box 660717, Dallas, TX 75266-0717. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and will return all of your payments.

POLICY REPLACEMENT

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

NOTICE

This policy may not fully cover all of your medical costs. Neither Blue Cross and Blue Shield of Texas nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. Blue Cross and Blue Shield of Texas will void (rescind) your policy back to its effective date and refuse to pay any claims if you leave out or falsify important information (medical and health history). Also, any claims paid will be deducted from any premium refund that may be due. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

LIMITATIONS AND EXCLUSIONS

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

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

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

SUSPENSION AND/OR REFUND OF PREMIUM

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

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

MEDICARE SELECT ADDITIONAL DISCLOSURES

GRIEVANCE PROCEDURES

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

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

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

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

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

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

If you are dissatisfied with the decision of our Grievance Committee you may submit a written complaint to the Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, fax (512) 475-1771 or email at ConsumerProtection@tdi.state.tx.us.

QUALITY ASSURANCE

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

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

MEDICARE SELECT HOSPITAL RESTRICTIONS

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

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

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

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

Plan A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: – Additional 365 days – Beyond the additional 365 days	All but \$1,132 All but \$283 a day All but \$566 a day \$0 \$0	\$0 \$283 a day \$566 a day 100% of Medicare-eligible expenses \$0	\$1,132 (Part A deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$141.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$141.50 a day All costs
BLOOD First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0

Plan A

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

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
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****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.

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

* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (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 three pints Next \$162 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$162 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Plan A

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$162 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$162 (Part B deductible) \$0

Plan F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: – Additional 365 days – Beyond the additional 365 days	All but \$1,132 All but \$283 a day All but \$566 a day \$0 \$0	\$1,132 (Part A deductible) ¹ \$283 a day \$566 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0 All costs
BLOOD First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0

¹Medicare Select Plans require that you use a Blue Cross and Blue Shield of Texas Network Hospital for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the \$1,132 deductible is covered at any hospital from which you receive care.

Plan F

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

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
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*****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.

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

* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$162 of Medicare-approved amounts*	\$0	\$162 (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 three pints Next \$162 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$162 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Plan F

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$162 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$162 (Part B deductible) 20%	\$0 \$0 \$0

OTHER BENEFITS — NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

High Deductible Plan F

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

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

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year \$2,000 deductible.

Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,000 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$2,000 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: – Additional 365 days – Beyond the additional 365 days	All but \$1,132 All but \$283 a day All but \$566 a day \$0 \$0	\$1,132 (Part A deductible) \$283 a day \$566 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0 All costs
BLOOD First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0

High Deductible Plan F

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

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
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*** **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.

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

- * Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.
- ** **This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year \$2,000 deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,000 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$2,000 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 \$162 of Medicare-approved amounts*	\$0	\$162 (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

High Deductible Plan F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR (continued)

BLOOD				
First three pints	\$0		All costs	\$0
Next \$162 of Medicare-approved amounts*	\$0		\$162 (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 \$2,000 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$2,000 DEDUCTIBLE**, YOU PAY
HOME HEALTH CARE				
MEDICARE-APPROVED SERVICES				
– Medically necessary skilled care services and medical supplies	100%		\$0	\$0
– Durable medical equipment				
First \$162 of Medicare-approved amounts*	\$0		\$162 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%		20%	\$0

OTHER BENEFITS — NOT COVERED BY MEDICARE

SERVICES		MEDICARE PAYS	AFTER YOU PAY \$2,000 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$2,000 DEDUCTIBLE**, YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE				
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA				
First \$250 each calendar year	\$0		\$0	\$250
Remainder of charges	\$0		80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Plan G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: – Additional 365 days – Beyond the additional 365 days	All but \$1,132 All but \$283 a day All but \$566 a day \$0 \$0	\$1,132 (Part A deductible) ¹ \$283 a day \$566 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0 All costs
BLOOD First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0

¹Medicare Select Plans require that you use a Blue Cross and Blue Shield of Texas Network Hospital for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the \$1,132 deductible is covered at any hospital from which you receive care.

Plan G

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

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
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****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.

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

* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (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 three pints	\$0	All costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Plan G

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$162 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100%	\$0	\$0
	\$0 80%	\$0 20%	\$162 (Part B deductible) \$0

OTHER BENEFITS — NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

Plan K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4,640 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, 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.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: – Additional 365 days – Beyond the additional 365 days	All but \$1,132 All but \$283 a day All but \$566 a day \$0 \$0	\$566 (50% of Part A deductible) ¹ \$283 a day \$566 a day 100% of Medicare-eligible expenses \$0	\$566 (50% of Part A deductible)◆ \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$70.75 a day \$0	\$0 Up to \$70.75 a day◆ All costs
BLOOD First three pints Additional amounts	\$0 100%	50% \$0	50%◆ \$0

¹Medicare Select Plans require that you use a Blue Cross and Blue Shield of Texas Network Hospital for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the \$1,132 deductible is covered at any hospital from which you receive care.

Plan K

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

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 ♦
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***** 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.

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

******** Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with asterisks), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First \$162 of Medicare-approved amounts**** Preventive benefits for Medicare-covered services	\$0 Remainder of Medicare-approved amounts	\$162 (Part B deductible)****♦ All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 75% or more of Medicare-approved amounts	Generally 10%	Generally 10% ♦
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$4,640)*

Plan K

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR (continued)

BLOOD First three pints	\$0		50% ♦	50% ♦
	\$0		\$0	\$162 (Part B deductible)****♦
Remainder of Medicare-approved amounts	Generally 80%		Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%		\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$4,640 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$162 of Medicare-approved amounts**** Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 10%	\$0 \$162 (Part B deductible) ♦ 10% ♦

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

Plan L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,320 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, 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.**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: – Additional 365 days – Beyond the additional 365 days	All but \$1,132 All but \$283 a day All but \$566 a day \$0 \$0	\$849 (75% of Part A deductible) ¹ \$283 a day \$566 a day 100% of Medicare-eligible expenses \$0	\$283 (25% of Part A deductible) ♦ \$0 \$0 \$0 *** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$106.13 a day \$0	\$0 Up to \$35.37 a day ♦ All costs
BLOOD First three pints Additional amounts	\$0 100%	75% \$0	25% ♦ \$0

¹Medicare Select Plans require that you use a Blue Cross and Blue Shield of Texas Network Hospital for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the \$1,132 deductible is covered at any hospital from which you receive care.

Plan L

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

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◆
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***** 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.

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

******** Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with asterisks), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$162 of Medicare-approved amounts**** Preventive benefits for Medicare-covered services Remainder of Medicare-approved amounts	\$0 Generally 75% or more of Medicare-approved amounts Generally 80%	\$0 Remainder of Medicare-approved amounts Generally 15%	\$162 (Part B deductible)****◆ All costs above Medicare-approved amounts Generally 5%◆
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$2,320)*

Plan L

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR (continued)

BLOOD First three pints	\$0	75%	25%◆	
	\$0	\$0	\$162 (Part B deductible)◆	
	Generally 80%	Generally 15%	Generally 5%◆	
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0	

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$2,320 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PARTS A & B)				
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*	
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$162 of Medicare-approved amounts***** Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 15%	\$0 \$162 (Part B deductible)◆ 5%◆	

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

Plan N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: – Additional 365 days – Beyond the additional 365 days	All but \$1,132 All but \$283 a day All but \$566 a day \$0 \$0	\$1,132 (Part A deductible) ¹ \$283 a day \$566 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0 All costs
BLOOD First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0

¹Medicare Select Plans require that you use a Blue Cross and Blue Shield of Texas Network Hospital for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the \$1,132 deductible is covered at any hospital from which you receive care.

Plan N

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

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
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**** 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.

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

* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$162 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 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.	\$162 (Part B deductible) 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

Plan N

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR (continued)

BLOOD				
First three pints	\$0	All costs	\$0	\$0
Next \$162 of Medicare-approved amounts*	\$0		\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	80%		20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%		\$0	\$0

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS — NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Applicant Name _____

PART ONE (continued)

Section D: Medicare Claim Number

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

Your Medicare Claim No. - Part A Effective Date: ____/ **01** / ____

Section E: Consumer Protection Information

Please answer all questions. Please mark Yes or No below with an "X" to the best of your knowledge.

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

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

If **yes**, what is the effective date? ____/____/____

3. Are you covered for medical assistance through the state Medicaid program? Yes No

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

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

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

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

Start: ____/____/____
End: ____/____/____

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

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

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

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

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

b. If **yes**, do you intend to replace your current Medicare Supplement or Medicare Advantage policy? Yes No

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

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

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

Start: ____/____/____
End: ____/____/____

PART ONE (continued)

Section F: Guaranteed Issue Eligibility

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

If you answer “yes” to questions 1-8 below, and if you are applying before the 63rd day after your coverage terminated, you are eligible for guarantee issuance of this Medicare Supplement policy. Please place an “X” in the box next to the Guarantee Issue statement for which you qualify. Please proceed to page 7. Read the representations, acknowledgements and authorizations. Sign the application. Your application is complete and ready to be submitted.

Have any of the following events listed below, and on the next page, occurred? Yes No

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan.

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

3. The individual is enrolled with an entity listed in subparagraphs (A)-(D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual’s election of coverage under paragraph (2) of this subsection: (A) an eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost); (B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999; (C) an organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or (D) an organization under a Medicare Select policy.

PART ONE – Section F (continued)

- 4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because: (A) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or of other involuntary termination of coverage or enrollment under the policy; (B) the issuer of the policy substantially violated a material provision of the policy; or (C) the issuer, or an agent or other entity acting on the issuer’s behalf, materially misrepresented the policy’s provisions in marketing the policy to the individual.

- 5. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under section 1851 (e) of the Social Security Act).

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

- 7. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (c)(4) of this section.

- 8. The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

PART TWO: Health History/Medical Questions



Note: Anyone in Open Enrollment or if you have determined that you are eligible for Guaranteed Issue based on SECTION F, “Guaranteed Issue Eligibility,” you are not required to answer the following health questions. Please continue to PART THREE.

Please answer the following health history questions.

- 1. What is your height? Ft. In.

- 2. What is your weight? Lbs.

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

PART TWO (continued)

4. Within the past 5 years, have you been diagnosed, treated, hospitalized or recommended for treatment, including drug therapy, by a physician or any other provider for any of the following:
- a. Diabetes with amputation, loss of sight or complications affecting the kidney? Yes No
 - b. Organ or tissue transplant (except cornea)? Yes No
 - c. Cancer (excluding basal cell or squamous cell cancer of the skin)? Yes No
 - d. Leukemia or Hodgkin’s disease? Yes No
 - e. Stroke, Transient Ischemic Attack (TIA)? Yes No
 - f. Alzheimer’s disease, senility, dementia or brain disorder? Yes No
 - g. Parkinson’s disease? Yes No
 - h. Carotid artery disease, heart attack, or heart by-pass surgery or angioplasty? Yes No
 - i. Congestive heart failure or heart valve replacement? Yes No
 - j. Nephritis or kidney failure? Yes No
 - k. Cirrhosis of the liver or Hepatitis C? Yes No
 - l. Multiple Sclerosis or neuromuscular disorders? Yes No
 - m. Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig’s disease)? Yes No
 - n. Respiratory or lung disease requiring use of oxygen? Yes No
 - o. Alcohol or chemical dependency? Yes No
5. Within the past 5 years, have you been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or human immunodeficiency virus (HIV) infection? Yes No
6. Within the past 2 years, have you been advised to have kidney dialysis, joint replacement, or surgery for the heart, arteries or intestines that has not yet been done? Yes No
7. Within the past 2 years, have you been hospitalized 2 or more times, or have you been confined to a nursing home for 14 or more days? Yes No
8. Are you currently confined, or has confinement been recommended to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a wheelchair or a home health care agency? Yes No
9. Do you need or receive help from any other person to perform any of the activities below because of health or physical difficulty? Yes No
- Taking Medications
 - Eating
 - Walking
 - Bathing
 - Dressing
 - Toileting
 - Moving from place to place in your home
 - Getting in and out of bed or chairs

Applicant Name _____

PART THREE: Representations, Acknowledgements, and Authorizations

I have read and understand the statements below regarding Medicare Supplement coverage from Blue Cross and Blue Shield of Texas, which is herein called the Company. If choosing Medicare Select, I have also read and understand the statements regarding Medicare Select as described in the enclosed Outline of Coverage. I have received an Outline of Coverage for the policy I applied for.

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

I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws.

I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and, provided the Company approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

Important Information Regarding Medicare Supplement Coverage:

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

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

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

Applicant Name _____

PART THREE (continued)

I hereby apply for coverage and request an inspection policy for the Medicare Supplement policy indicated. I understand that once my first premium payment is received, I will be covered as of the date shown on the Company identification card. Once coverage begins, I understand I have 30 days to return my policy materials and receive a full refund for any premiums paid. Services are covered only when received on or after the effective date of the policy chosen, except in the case of inpatient services, where the admission must occur on or after the effective date to be covered.

I hereby declare that the statements and answers on this application, including but not limited to those relating to age and medical history, are true and complete to the best of my knowledge and belief. I agree that the Company, believing them to be true, shall rely and act upon them accordingly. I hereby agree to furnish any additional information, if requested. If I falsify or fail to include all material information (e.g. age and medical history) required on this application, my policy will be rescinded by the Company. Rescission means voiding my policy back to its effective date. If my policy is rescinded, any premiums paid (less any benefits paid) will be refunded.

I understand that the Company has the right to reject my application. If the Company rejects my application, I will be notified in writing. If this application is accepted, it will become part of the insurance policy.

SIGNATURE REQUIRED

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

Applicant **X** _____ Date: ____/____/____

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

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

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

Applicant Name _____

PART THREE (continued)

Agent Information (If Applicable)

The following statements apply if you are purchasing coverage through an agent:

- The undersigned acknowledges that any agent is acting on his/her behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an individual policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such individual policy.
- The undersigned further acknowledges that if he/she desires additional information regarding any commissions or other compensation paid to the agent by the Company in connection with the issuance of the individual policy, he/she should contact the agent.
- The applicant(s) have received a copy(s) of the Medicare Supplement Buyers Guide.

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

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

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

Signature: **X** _____ Date: ____/____/____

Print name: Mark Deschenes Texas Broker Code: 6856

Agency name (If Applicable): Deschenes Financial Services, Inc Phone: (800) 257-1723

Agency Fax Number: 1-888-770-8818

Insert Application for Medicare Supplement Plan

Get the Blue difference...

To ensure fast processing of your Medicare Supplement Insurance Plan coverage, please complete the entire application.

Have you:

- Selected a Medicare Supplement Insurance Plan?
- Included your Social Security Number?
- Provided your Medicare Card Number?
- Signed and dated your application?
- Made sure the blue-stripped application is inserted in this envelope?

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



BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.®

For more information and assistance
call your BCBSTX authorized agent.

A business card for Mark Deschenes, Principal Insurance Agent. The card is white with a blue header and footer. The text on the card includes: **Mark Deschenes**, Principal Insurance Agent, Ph. 1.800.257.1723 Fax. 1.888.770.8818, mark@health-life-dental-insurance.com, P.O. Box 781769, San Antonio, TX 78278. The footer features three icons: a red cross, a yellow person, and a blue tooth, with the words 'Health Life Dental' below them and 'Insurance' in a large font below that.

Mark Deschenes
Principal Insurance Agent
Ph. 1.800.257.1723 Fax. 1.888.770.8818
mark@health-life-dental-insurance.com
P.O. Box 781769
San Antonio, TX 78278

Health Life Dental
Insurance

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

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® Registered Service Mark of Health Care Service Corporation

SM Service Marks of Health Care Service Corporation



Notice to Applicant Regarding REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

Save this notice! It may be important to you in the future.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage coverage and replace it with a policy to be issued by Blue Cross and Blue Shield of Texas. Your new policy will provide 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

Statement to Applicant by Issuer:

I have reviewed your current medical or health coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reasons:

- Additional benefits,
Same benefits but lower premiums,
Fewer benefits and lower premiums,
My plan has outpatient prescription drug coverage and I am enrolling in Part D,
Disenrollment from a Medicare Advantage plan.
Other (specify)

I call to your attention the following items for your consideration:

- 1. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the issuer to deny any future claims and to refund your premium as though the policy had never been in force. After the application has been completed and before you sign it, read and review it carefully to be certain that all information has been properly recorded.
2. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Agent's Signature

Agent's Number

Printed Name and Address of Agent

Applicant's Signature

Date

Note to Agent: You and the applicant who is replacing existing health insurance with Blue Cross and Blue Shield coverage must read, sign, and date this replacement form. You must then submit the white copy along with the application. The yellow copy must remain with the applicant.