



Medicare Supplement insurance can be sold in only 10 standard plans plus two high-deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan A. Some plans may not be available in Texas.

BASIC BENEFITS: Included in all plans.
 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 in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments.
 Blood: First three pints of blood each year.

A	B	C	D	E	F	F *	G	H	I	J	J *
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		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	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
								Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Extended Drugs (\$3,000 Limit)	
				Preventive Care						Preventive Care	

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.

* Plans F and J also have an option called a high-deductible Plan F and a high-deductible Plan J. These high-deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar-year \$1,730 deductible. Benefits from high-deductible Plans F and J will not begin until out-of-pocket expenses are \$1,730 paid. 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, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.



**BlueCross BlueShield
of Texas**

**2005
MEDICARE SUPPLEMENT MONTHLY RATES BY AREA**

3-Digit Zips for Area 1:

754-759, 763-769, 778-792, 795, 797-799, 885

3-Digit Zips for Area 2:

750-753, 760-762, 776-777, 793-794, 796

Area 1 Rates By Plan:

Plan A:	65-66	\$112.00
	67-69	\$129.00
	70-74	\$151.00
	75-79	\$169.00
	80-84	\$190.00
	85+	\$206.00
Plan D:	65-66	\$114.00
	67-69	\$133.00
	70-74	\$158.00
	75-79	\$176.00
	80-84	\$199.00
	85+	\$215.00
Plan F:	65-66	\$125.00
	67-69	\$143.00
	70-74	\$168.00
	75-79	\$189.00
	80-84	\$213.00
	85+	\$231.00

Area 2 Rates By Plan:

Plan A:	65-66	\$122.00
	67-69	\$142.00
	70-74	\$167.00
	75-79	\$185.00
	80-84	\$212.00
	85+	\$227.00
Plan D:	65-66	\$128.00
	67-69	\$148.00
	70-74	\$173.00
	75-79	\$194.00
	80-84	\$220.00
	85+	\$237.00
Plan F:	65-66	\$137.00
	67-69	\$158.00
	70-74	\$185.00
	75-79	\$210.00
	80-84	\$236.00
	85+	\$255.00

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**

**2005
MEDICARE SUPPLEMENT MONTHLY RATES BY AREA**

**3-Digit Zips for Area 3:
770-775, out-of-state**

Area 3 Rates By Plan:

Plan A:	65-66	\$136.00
	67-69	\$156.00
	70-74	\$183.00
	75-79	\$207.00
	80-84	\$233.00
	85+	\$250.00
Plan D:	65-66	\$143.00
	67-69	\$162.00
	70-74	\$190.00
	75-79	\$215.00
	80-84	\$242.00
	85+	\$263.00
Plan F:	65-66	\$153.00
	67-69	\$174.00
	70-74	\$204.00
	75-79	\$230.00
	80-84	\$261.00
	85+	\$282.00

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DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN YOUR POLICY

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

POLICY REPLACEMENT

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

NOTICE

This policy may not fully cover all of your medical costs. Blue Cross and Blue Shield of Texas is not connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" 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 age and medical 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 (age and medical 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.

REFUND OF PREMIUM

Upon termination of this Policy in any manner, including death of the Subscriber, the Issuer 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.)

Questions? Call 1-800-654-9390

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.

**\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN A PAYS	WITH PLAN A 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 \$912 All but \$228 a day All but \$456 a day \$0 \$0	\$0 \$228 a day \$456 a day 100% of Medicare-eligible expenses \$0	\$912 (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 \$114.00 a day \$0	\$0 \$0 \$0	\$0** Up to \$114.00 a day All costs
BLOOD — First three pints Additional amounts	\$0 100%	Three pints \$0	\$0** \$0**
HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

*Once you have been billed \$110 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.

**\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

† By law, no physician may charge more than 115% of Medicare-approved amounts.

SERVICES	MEDICARE PAYS	PLAN A PAYS	WITH PLAN A 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 \$110 of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B excess charges (above Medicare-approved amounts)†	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$110 (Part B deductible) \$0** All costs
BLOOD — First three pints Next \$110 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0** \$110 (Part B deductible) \$0**
CLINICAL LABORATORY SERVICES — BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0**

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN A PAYS	WITH PLAN A YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0**
– Durable medical equipment			
First \$110 of Medicare-approved amounts*	\$0	\$0	\$110 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0**
AT-HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
– Benefit for each visit	\$0	\$0	All costs
– Number of visits covered (must be received within eight weeks of last Medicare-approved visit)	\$0	\$0	All costs
– Calendar year maximum	\$0	\$0	All costs

OTHER BENEFITS — NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	PLAN A PAYS	WITH PLAN A YOU PAY
FOREIGN TRAVEL — NOT COVERED BY MEDICARE			
Medically necessary emergency care services needed immediately because of an accidental injury or illness of sudden and unexpected onset, beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	\$0	All costs

Plan D

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.

**\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN D PAYS	WITH PLAN D 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 \$912 All but \$228 a day All but \$456 a day \$0 \$0	\$912 (Part A deductible) \$228 a day \$456 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 \$114.00 a day \$0	\$0 Up to \$114.00 a day \$0	\$0** \$0** All costs
BLOOD — First three pints Additional amounts	\$0 100%	Three pints \$0	\$0** \$0**
HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

*Once you have been billed \$110 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.

**\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

† By law, no physician may charge more than 115% of Medicare-approved amounts.

SERVICES	MEDICARE PAYS	PLAN D PAYS	WITH PLAN D 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 \$110 of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B excess charges (above Medicare-approved amounts)†	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$110 (Part B deductible) \$0** All costs
BLOOD — First three pints Next \$110 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0** \$110 (Part B deductible) \$0**
CLINICAL LABORATORY SERVICES — BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0**

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN D PAYS	WITH PLAN D YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$110 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0** \$110 (Part B deductible) \$0**
AT-HOME RECOVERY SERVICES NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan – Benefit for each visit – Number of visits covered (must be received within eight weeks of last Medicare-approved visit) – Calendar year maximum	\$0 \$0 \$0	Actual charges to \$40 a visit Up to the number of Medicare-approved visits, not to exceed seven each week \$1,600	Balance Balance Balance

OTHER BENEFITS — NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	PLAN D PAYS	WITH PLAN D YOU PAY
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services needed immediately because of an accidental injury or illness of sudden and unexpected onset, 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 benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

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.

**\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN F PAYS	WITH PLAN F 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 \$912 All but \$228 a day All but \$456 a day \$0 \$0	\$912 (Part A deductible) \$228 a day \$456 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 \$114.00 a day \$0	\$0 Up to \$114.00 a day \$0	\$0** \$0** All costs
BLOOD — First three pints Additional amounts	\$0 100%	Three pints \$0	\$0** \$0**
HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

*Once you have been billed \$110 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.

**\$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

† By law, no physician may charge more than 115% of Medicare-approved amounts.

SERVICES	MEDICARE PAYS	PLAN F PAYS	WITH PLAN F YOU PAY
<p>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</p> <p>First \$110 of Medicare-approved amounts*</p> <p>Remainder of Medicare-approved amounts</p> <p>Part B excess charges (above Medicare-approved amounts)†</p>	<p>\$0</p> <p>Generally 80%</p> <p>\$0</p>	<p>\$110 (Part B deductible)</p> <p>Generally 20%</p> <p>100%</p>	<p>\$0**</p> <p>\$0**</p> <p>\$0**</p>
<p>BLOOD —</p> <p>First three pints</p> <p>Next \$110 of Medicare-approved amounts*</p> <p>Remainder of Medicare-approved amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All costs</p> <p>\$110 (Part B deductible)</p> <p>20%</p>	<p>\$0**</p> <p>\$0**</p> <p>\$0**</p>
<p>CLINICAL LABORATORY SERVICES — BLOOD TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0**</p>

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN F PAYS	WITH PLAN F YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$110 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$110 (Part B deductible) 20%	\$0** \$0** \$0**
AT-HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan – Benefit for each visit – Number of visits covered (must be received within eight weeks of last Medicare-approved visit) – Calendar year maximum	\$0 \$0 \$0	\$0 \$0 \$0	All costs All costs All costs

OTHER BENEFITS — NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	PLAN F PAYS	WITH PLAN F YOU PAY
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services needed immediately because of an accidental injury or illness of sudden and unexpected onset, 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 benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

