

Plan65

Outline of Medicare Supplement Coverage 2012

Benefit Plans A, F, N and High Deductible F
Blue Plan65 Select F and N



BlueCross BlueShield of Oklahoma

Experience. Wellness. Everywhere.®



These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan “A”.
Some plans may not be available in your state. Blue Cross and Blue Shield of Oklahoma does not offer those plans shaded in gray below.

BASIC BENEFITS:

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

A	B	C	D	F	F*	G	K	L	M	N
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	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	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)	Part B Excess (100%)					
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency				Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$4,660; paid at 100% after limit reached	Out-of-pocket limit \$2,330; 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 \$2,070 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,070. 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 emergency deductible.

MONTHLY PREMIUM INFORMATION

We, Blue Cross and Blue Shield of Oklahoma, can only raise your premium if we raise the premium for all policies like yours in this State. Your premium is based upon your age at the time you enroll in Plan65, as well as on the amount of time you have been covered by Medicare Part B prior to enrollment.

Attained Age	Plan A		Plan F		Plan F HD*		Plan N	
	Male	Female	Male	Female	Male	Female	Male	Female
65	\$93.00	\$84.80	\$138.70	\$126.50	\$23.20	\$21.30	\$97.10	\$88.60
66	\$95.90	\$87.40	\$143.30	\$130.50	\$24.00	\$21.90	\$100.20	\$91.30
67	\$99.10	\$90.30	\$147.80	\$134.70	\$24.80	\$22.60	\$103.50	\$94.30
68	\$102.30	\$93.10	\$152.50	\$139.00	\$25.60	\$23.20	\$106.70	\$97.30
69	\$105.40	\$95.90	\$157.30	\$143.30	\$26.40	\$24.00	\$110.00	\$100.20
70	\$108.60	\$99.00	\$161.90	\$147.60	\$27.10	\$24.70	\$113.30	\$103.40
71	\$112.00	\$102.10	\$166.90	\$152.20	\$27.90	\$25.50	\$116.90	\$106.50
72	\$115.20	\$105.10	\$171.90	\$156.80	\$28.80	\$26.30	\$120.40	\$109.70
73	\$118.60	\$108.10	\$177.10	\$161.30	\$29.70	\$27.00	\$123.90	\$112.90
74	\$122.00	\$111.30	\$182.10	\$166.00	\$30.60	\$27.80	\$127.60	\$116.20
75	\$125.60	\$114.40	\$187.50	\$170.90	\$31.40	\$28.60	\$131.20	\$119.70
76	\$129.10	\$117.70	\$192.70	\$175.70	\$32.20	\$29.40	\$134.90	\$122.90
77	\$132.60	\$120.90	\$198.00	\$180.50	\$33.20	\$30.30	\$138.70	\$126.20
78	\$136.40	\$124.30	\$203.40	\$185.40	\$34.10	\$31.10	\$142.50	\$129.80
79	\$140.00	\$127.50	\$208.90	\$190.40	\$35.00	\$31.90	\$146.20	\$133.30
80	\$143.70	\$131.00	\$214.40	\$195.40	\$35.90	\$32.80	\$150.10	\$136.70
81	\$147.40	\$134.30	\$219.90	\$200.50	\$36.90	\$33.70	\$153.90	\$140.30
82	\$151.20	\$137.90	\$225.50	\$205.60	\$37.70	\$34.50	\$157.90	\$143.90
83	\$154.80	\$141.10	\$231.10	\$210.60	\$38.70	\$35.30	\$161.70	\$147.50
84	\$158.60	\$144.60	\$236.70	\$215.90	\$39.60	\$36.20	\$165.60	\$151.10
85+	\$175.00	\$159.40	\$261.10	\$238.00	\$43.80	\$39.90	\$182.90	\$166.50

*High Deductible Plan F offers the same benefits as Plan F after one has paid a calendar year \$2,070 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 your insurance company.

RIGHT TO RETURN YOUR POLICY

If you find that you are not satisfied with your policy, you may return it to Medicare Supplement Membership, P.O. Box 3004, Naperville, IL 60566. 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 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 Oklahoma nor its authorized 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. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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

Plan A

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

*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
<p>HOSPITALIZATION*</p> <p>Semiprivate room and board, general nursing, and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st through 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: <ul style="list-style-type: none"> – Additional 365 days – Beyond the additional 365 days 	<p>All but \$1,156</p> <p>All but \$289 a day</p> <p>All but \$578 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$289 a day</p> <p>\$578 a day</p> <p>100% of Medicare-eligible expenses</p> <p>\$0</p>	<p>\$1,156 (Part A deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE*</p> <p>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</p> <p>First 20 days</p> <p>21st through 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$144.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$144.50 a day</p> <p>All costs</p>
<p>BLOOD</p> <p>First three pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>Three pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>

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 \$140 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 physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$140 (Part B deductible) \$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First three pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$140 (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	100%	\$0	\$0
– Durable medical equipment			
First \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

Plan F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION*</p> <p>Semiprivate room and board, general nursing, and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st through 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: <ul style="list-style-type: none"> – Additional 365 days – Beyond the additional 365 days 	<p>All but \$1,156</p> <p>All but \$289 a day</p> <p>All but \$578 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1,156 (Part A deductible)</p> <p>\$289 a day</p> <p>\$578 a day</p> <p>100% of Medicare-eligible expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE*</p> <p>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</p> <p>First 20 days</p> <p>21st through 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$144.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$144.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD</p> <p>First three pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>Three pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>

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 \$140 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 physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$140 (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	100%	\$0
BLOOD First three pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts*	\$0 \$0 80%	All costs \$140 (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	100%	\$0	\$0
– Durable medical equipment			
First \$140 of Medicare-approved amounts*	\$0	\$140 (Part B deductible)	\$0
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

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 \$2,070 deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are \$2,070. 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 \$2,070 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$2,070 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,156	\$1,156 (Part A deductible)	\$0
61st through 90th day	All but \$289 a day	\$289 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$578 a day	\$578 a day	\$0
– Once Lifetime Reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0***
– Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st through 100th day	All but \$144.50 a day	Up to \$144.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	Three pints	\$0
Additional amounts	100%	\$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 \$140 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	AFTER YOU PAY \$2,070 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$2,070 DEDUCTIBLE**, YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$140 (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	\$0	100%	\$0
BLOOD First three pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$140 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

High Deductible Plan F

MEDICARE (PARTS A & B)

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,070 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$2,070 DEDUCTIBLE**, YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First \$140 of Medicare-approved amounts*	\$0	\$140 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,070 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$2,070 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 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
<p>HOSPITALIZATION*</p> <p>Semiprivate room and board, general nursing, and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st through 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> – While using 60 Lifetime Reserve days – Once Lifetime Reserve days are used: <ul style="list-style-type: none"> – Additional 365 days – Beyond the additional 365 days 	<p>All but \$1,156</p> <p>All but \$289 a day</p> <p>All but \$578 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1,156 (Part A deductible)</p> <p>\$289 a day</p> <p>\$578 a day</p> <p>100% of Medicare-eligible expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE*</p> <p>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</p> <p>First 20 days</p> <p>21st through 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$144.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$144.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD</p> <p>First three pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>Three pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>

Plan N

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD (CONTINUED)

<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/coinsurance</p>	<p>\$0</p>
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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 \$140 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
<p>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment</p> <p>First \$140 of Medicare-approved amounts*</p> <p>Remainder of Medicare-approved amounts</p>	<p>\$0</p> <p>Generally 80%</p>	<p>\$0</p> <p>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.</p>	<p>\$140 (Part B deductible)</p> <p>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.</p>
<p>PART B EXCESS CHARGES (above Medicare-approved amounts)</p>	<p>\$0</p>	<p>\$0</p>	<p>All costs</p>

Plan N

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

BLOOD			
First three pints	\$0	All costs	\$0
Next \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (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 \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (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

Blue Cross and Blue Shield of Oklahoma

Outline of Medicare Supplement Coverage – Benefit Plan F *Select* and N *Select*

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan “A”. Some plans may not be available in your state. Blue Cross and Blue Shield of Oklahoma does not offer those plans shaded in gray below.

BASIC BENEFITS:

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

A	B	C	D	F	F*	G	K	L	M	N
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%.	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%.	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$4,660; paid at 100% after limit reached	Out-of-pocket limit \$2,330; 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 \$2,070 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,070. 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 emergency deductible.

Medicare Select Plans require that you use a Blue Cross and Blue Shield of Oklahoma 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.

MONTHLY PREMIUM INFORMATION

We, Blue Cross and Blue Shield of Oklahoma, can only raise your premium if we raise the premium for all policies like yours in this State. Your premium is based upon your age at the time you enroll in Plan65, as well as on the amount of time you have been covered by Medicare Part B prior to enrollment.

Attained Age	Blue Plan65 Select Plan F		Blue Plan65 Select Plan N	
	Male	Female	Male	Female
65	\$117.80	\$107.40	\$82.50	\$75.10
66	\$121.60	\$110.70	\$85.10	\$77.60
67	\$125.60	\$114.30	\$87.80	\$80.10
68	\$129.50	\$117.90	\$90.50	\$82.60
69	\$133.50	\$121.60	\$93.60	\$85.10
70	\$137.50	\$125.40	\$96.20	\$87.70
71	\$141.70	\$129.20	\$99.20	\$90.30
72	\$145.90	\$133.10	\$102.10	\$93.30
73	\$150.40	\$136.80	\$105.20	\$95.90
74	\$154.70	\$140.90	\$108.20	\$98.80
75	\$159.20	\$145.00	\$111.40	\$101.60
76	\$163.60	\$149.10	\$114.60	\$104.30
77	\$168.10	\$153.20	\$117.70	\$107.20
78	\$172.70	\$157.40	\$120.90	\$110.30
79	\$177.40	\$161.60	\$124.10	\$113.10
80	\$182.00	\$165.80	\$127.50	\$116.20
81	\$186.60	\$170.10	\$130.70	\$119.10
82	\$191.30	\$174.50	\$133.90	\$122.10
83	\$196.30	\$178.80	\$137.40	\$125.20
84	\$201.00	\$183.10	\$140.70	\$128.30
85+	\$221.80	\$202.10	\$155.20	\$141.50

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN YOUR POLICY

If you find that you are not satisfied with your policy, you may return it to Medicare Supplement Membership, P.O. Box 3004, Naperville, IL 60566. 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 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 Oklahoma nor its authorized 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. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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

ADDITIONAL DISCLOSURES FOR BLUE PLAN 65 SELECT

YOUR BLUE PLAN 65 SELECT NETWORK PROVIDER

By choosing Blue Plan65 Select as your Medicare Supplement, you are agreeing to receive services from a Blue Plan65 Select Network Provider in order to receive the highest level of benefits. For the most updated list of our Blue Plan Select Network Providers please visit our Web site at *bcbso.com*. If you receive Covered Services from an Out-of-Network Provider, and the services were available from a Blue Plan65 Select Network Provider, those services will be reimbursed at a lower level of benefits, except for Emergency Care.

RESTRICTED BLUE PLAN65 SELECT NETWORK PROVIDER PROVISIONS

If you receive non-emergency services from a Provider other than a Blue Plan65 Select Network Provider, coverage for the supplemental portion of the Medicare services will be reduced as follows:

- No coverage will be provided for the Medicare Part A Deductible amount (the first \$1,156 of the Medicare Approved Amounts). You will be responsible for this amount.
- No coverage will be provided for the Medicare Part A Coinsurance amount for the 21st through 100th days in a post-hospital Skilled Nursing Facility. You will be responsible for this amount.
- No coverage will be provided for the Medicare Part B Deductible Amount (the first \$140 of the Medicare Approved Amounts). You will be responsible for this amount.
- No coverage will be provided for the difference between the actual Medicare Part B charge as billed, and the Medicare-approved Part B charge. You may be responsible for this difference if your Provider does not accept Medicare assignment.

COVERAGE FOR EMERGENCY CARE

Benefits for Emergency Care, which are Medicare Eligible Expenses, will be provided at the Blue Plan65 *Select* Network level regardless of whether a Blue Plan65 *Select* Network Provider is used. This includes services which are immediately required for an unforeseen illness, injury or condition, and it is not reasonable to obtain the services through a Blue Plan65 *Select* Network Provider.

GRIEVANCE PROCEDURE

Blue Cross and Blue Shield of Oklahoma is committed to providing quality, responsive administration of benefits and customer service to our Members. Our corporation provides dedicated customer service to Medicare Supplement Members. This service capability provides dedicated staff, dedicated telephone lines and dedicated toll-free telephone access.

Member inquiries with regard to claims payment, billing, coverage levels, benefit interpretation, network provider and other miscellaneous concerns are addressed by the dedicated customer service unit of our Customer Service Department in Tulsa, Oklahoma.

If your inquiry is not resolved through our dedicated customer service area to your satisfaction, a grievance procedure is in place to seek further review or clarification and is outlined in the Policy.

QUALITY ASSURANCE PROGRAM

All Blue Plan65 *Select* Network Providers are chosen based on specific written criteria and are periodically evaluated for quality of care provided. Processes are in place to initiate corrective action when warranted.

Blue Plan65 *Select* Network Providers are issued written criteria for retention in and removal from the network.

RIGHT TO PURCHASE

You have the right to apply for any Medicare Supplement Policy offered by Blue Cross and Blue Shield of Oklahoma. If you enroll under this Blue Plan65 *Select* Medicare Supplement Policy, you may change coverage to any Medicare Supplement Policy offering comparable or lesser benefits by giving 31 days written notice of exchange.

Blue Plan65 Select – 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	BLUE PLAN65 SELECT IN-NETWORK BENEFITS	YOU PAY IN-NETWORK	OUT-OF-NETWORK BENEFITS	YOU PAY OUT-OF-NETWORK
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies					
First 60 days	All but \$1,156	\$1,156 (Part A deductible)	\$0	\$0	\$1,156 (Part A deductible)
61st through 90th day	All but \$289 a day	\$289 a day	\$0	\$289 a day	\$0
91st day and after:					
– While using 60 Lifetime Reserve days	All but \$578 a day	\$578 a day	\$0	\$578 a day	\$0
– Once Lifetime Reserve days are used:					
– Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0	100% of Medicare-eligible expenses	\$0
– Beyond the additional 365 days	\$0	\$0	All costs	\$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	All approved amounts	\$0	\$0	\$0	\$0
21st through 100th day	All but \$144.50 a day	Up to \$144.50 a day	\$0	\$0	Up to \$144.50 a day
101st day and after	\$0	\$0	All costs	\$0	All costs
BLOOD					
First three pints	\$0	Three pints	\$0	Three pints	\$0
Additional amounts	100%	\$0	\$0	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0	Medicare copayment/ coinsurance	\$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

† Medicare Select Plans require that you use a Blue Cross and Blue Shield of Oklahoma Hospital for non-emergency admissions to receive coverage for the Part A deductible. In an emergency, the \$1,156 deductible is covered at any hospital from which you receive care.

Blue Plan65 Select – Plan F

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

*Once you have been billed \$140 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	BLUE PLAN65 SELECT IN-NETWORK BENEFITS	YOU PAY IN-NETWORK	OUT-OF-NETWORK BENEFITS	YOU PAY OUT-OF-NETWORK
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$140 of Medicare approved Amounts* Remainder of Medicare-approved Amounts	\$0 80% (Generally)	\$140 (Part B Deductible) 20% (Generally)	\$0 \$0	\$0 20% (Generally)	\$140 (Part B Deductible) \$0
PART B EXCESS CHARGES (Above Medicare-approved Amounts)	\$0	100%	\$0	\$0	All Costs
BLOOD First three pints First \$140 of Medicare-approved Amounts* Remainder of Medicare-approved Amounts	\$0 \$0 80%	All Costs \$140 (Part B Deductible) 20%	\$0 \$0 \$0	All Costs \$0 20%	\$0 \$140 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES — Tests for Diagnostic Services	100%	\$0	\$0	\$0	\$0

Blue Plan65 Select – Plan F

PARTS A & B

SERVICES	MEDICARE PAYS	BLUE PLAN65 SELECT IN-NETWORK BENEFITS	YOU PAY IN-NETWORK	OUT-OF-NETWORK BENEFITS	YOU PAY OUT-OF-NETWORK
HOME HEALTH CARE MEDICARE-APPROVED SERVICES					
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0	\$0	\$0
• Durable medical equipment					
First \$140 of Medicare-approved Amounts*	\$0	\$140 (Part B Deductible)	\$0	\$0	\$140 (Part B Deductible)
Remainder of Medicare-approved Amounts	80%	20%	\$0	\$0	20%

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	BLUE PLAN65 SELECT IN-NETWORK BENEFITS	YOU PAY IN-NETWORK	OUT-OF-NETWORK BENEFITS	YOU PAY OUT-OF-NETWORK
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	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000*	20% and amounts over the \$50,000 lifetime maximum	80% to a lifetime maximum benefit of \$50,000*	20% and amounts over the \$50,000 lifetime maximum

Blue Plan65 Select – 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	BLUE PLAN65 SELECT IN-NETWORK BENEFITS	YOU PAY IN-NETWORK	OUT-OF-NETWORK BENEFITS	YOU PAY OUT-OF-NETWORK
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 \$1,156 All but \$289 a day All but \$578 a day \$0 \$0	\$1,156 (Part A deductible) \$289 a day \$578 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0 All costs	\$0 \$289 a day \$578 a day 100% of Medicare-eligible expenses \$0	\$1,156 (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 \$144.50 a day \$0	\$0 Up to \$144.50 a day \$0	\$0 \$0 All costs	\$0 \$0 \$0	\$0 Up to \$144.50 a day All costs
BLOOD First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0	Three pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0	Medicare copayment/coinsurance	\$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

¹Medicare Select Plans require that you use a Blue Cross and Blue Shield of Oklahoma Hospital for non-emergency admissions to receive coverage for the Part A deductible. In an emergency, the \$1,156 deductible is covered at any hospital from which you receive care.

Blue Plan65 Select – Plan N

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

*Once you have been billed \$140 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	BLUE PLAN65 SELECT IN-NETWORK BENEFITS	YOU PAY IN-NETWORK	OUT-OF-NETWORK BENEFITS	YOU PAY OUT-OF-NETWORK
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$140 of Medicare approved Amounts* Remainder of Medicare-approved Amounts	\$0 80% (Generally)	\$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.	\$140 (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.	\$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.	\$140 (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	\$0	All Costs
BLOOD First three pints First \$140 of Medicare-approved Amounts* Remainder of Medicare-approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$140 (Part B Deductible) \$0	All Costs \$0 20%	\$0 \$140 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – Tests for Diagnostic Services	100%	\$0	\$0	\$0	\$0

Blue Plan65 *Select* – Plan N

PARTS A & B

SERVICES	MEDICARE PAYS	BLUE PLAN65 SELECT IN-NETWORK BENEFITS	YOU PAY IN-NETWORK	OUT-OF-NETWORK BENEFITS	YOU PAY OUT-OF-NETWORK
HOME HEALTH CARE MEDICARE-APPROVED SERVICES					
Medically necessary skilled care services and medical supplies	100%	\$0	\$0	\$0	\$0
Durable medical equipment					
First \$140 of Medicare-approved Amounts*	\$0	\$0	All costs	\$0	All costs
Remainder of Medicare-approved Amounts	80%	20%	\$0	\$0	20%

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	BLUE PLAN65 SELECT IN-NETWORK BENEFITS	YOU PAY IN-NETWORK	OUT-OF-NETWORK BENEFITS	YOU PAY OUT-OF-NETWORK
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	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000*	20% and amounts over the \$50,000 lifetime maximum	80% to a lifetime maximum benefit of \$50,000*	20% and amounts over the \$50,000 lifetime maximum



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