

Plan65

Outline of Medicare Supplement Coverage 2009

Benefit Plans A, D, F, High Deductible F,
Blue Plan65 Select



**BlueCross BlueShield
of Oklahoma**

Blue Cross and Blue Shield of Oklahoma

Outline Of Medicare Supplement Coverage – Cover Page: 1 of 2

Benefit Plans A, D, F and F*

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 for plans A-J:

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.

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	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	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	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 Deductible
					Part B Excess (100%)	Part B Excess (80%)			Part B Excess (100%)	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	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	Preventive Care NOT covered by Medicare

*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 benefits as Plans F and J after one has paid a calendar year \$2,000 deductible. Benefits from high deductible Plans F and J 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. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan's separate foreign emergency deductible. High deductible Plan J is not currently available from Blue Cross and Blue Shield of Oklahoma.

Blue Cross and Blue Shield of Oklahoma

Outline Of Medicare Supplement Coverage – Cover Page: 2 of 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the Basic Benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits end 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits end 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	\$4,620 Out of Pocket Annual Limit***	\$2,310 Out-of-Pocket Annual Limit***

**Plans K and L provide for different cost-sharing for items and services than Plans A-J.

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your Provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

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.

PLAN A PREMIUMS			
	<u>Monthly</u>	<u>Quarterly</u>	<u>Semiannually</u>
Age 65-69 (Enrolled in Medicare Part B Less than Six Months)*	\$ 83.40	\$250.20	\$ 500.40
Age 65-69 (Enrolled in Medicare Part B Six Months or Longer)	\$104.20	\$312.60	\$ 625.20
Age 70+ (Enrolled in Medicare Part B Less than Six Months)	\$114.70	\$344.10	\$ 688.20
Age 70+ (Enrolled in Medicare Part B Six Months or Longer)	\$131.80	\$395.40	\$ 790.80
PLAN D PREMIUMS			
	<u>Monthly</u>	<u>Quarterly</u>	<u>Semiannually</u>
Age 65-69 (Enrolled in Medicare Part B Less than Six Months)*	\$117.80	\$353.40	\$ 706.80
Age 65-69 (Enrolled in Medicare Part B Six Months or Longer)	\$147.30	\$441.90	\$ 883.80
Age 70+ (Enrolled in Medicare Part B Less than Six Months)	\$162.00	\$486.00	\$ 972.00
Age 70+ (Enrolled in Medicare Part B Six Months or Longer)	\$186.30	\$558.90	\$1,117.80

* Members who enroll at ages 65-69 and during the first six months following their enrollment in Medicare Part B are eligible for a four-year discount of 20% the first year of enrollment, 15% the second year, 10% the third year, and 5% the fourth year. The premiums shown reflect the 20% discount available for the first year of enrollment. Early enrollment discounts are available to members who enroll in Plan65 for the first time January 1, 2006 or later.

PLAN F PREMIUMS			
	<u>Monthly</u>	<u>Quarterly</u>	<u>Semiannually</u>
Age 65-69 (Enrolled in Medicare Part B Less than Six Months) *	\$129.40	\$388.20	\$ 776.40
Age 65-69 (Enrolled in Medicare Part B Six Months or Longer)	\$161.70	\$485.10	\$ 970.20
Age 70+ (Enrolled in Medicare Part B Less than Six Months)	\$177.90	\$533.70	\$1,067.40
Age 70+ (Enrolled in Medicare Part B Six Months or Longer)	\$204.60	\$613.80	\$1,227.60
HIGH DEDUCTIBLE PLAN F* PREMIUMS			
	<u>Monthly</u>	<u>Quarterly</u>	<u>Semiannually</u>
Age 65-69 (Enrolled in Medicare Part B Less than Six Months)**	\$ 17.70	\$ 53.10	\$ 106.20
Age 65-69 (Enrolled in Medicare Part B Six Months or Longer)	\$ 22.10	\$ 66.30	\$ 132.60
Age 70+ (Enrolled in Medicare Part B Less than Six Months)	\$ 24.30	\$ 72.90	\$ 145.80
Age 70+ (Enrolled in Medicare Part B Six Months or Longer)	\$ 27.90	\$ 83.70	\$ 167.40

* High Deductible Plan F offers the same benefits as Plan F after one has paid a calendar year \$2,000 deductible.

** Members who enroll at ages 65-69 and during the first six months following their enrollment in Medicare Part B are eligible for a four-year discount of 20% the first year of enrollment, 15% the second year, 10% the third year, and 5% the fourth year. The premiums shown reflect the 20% discount available for the first year of enrollment. Early enrollment discounts are available to members who enroll in Plan65 for the first time January 1, 2006 or later.

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 POLICY

If you find that you are not satisfied with your policy, you may return it to Blue Cross and Blue Shield of Oklahoma, P. O. Box 3283, Tulsa, Oklahoma 74102-3283. 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.

Blue Cross and Blue Shield of Oklahoma 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 "*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 A PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <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 	All but \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$0 \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0	\$1,068 (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 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$133.50 a day All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 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

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

PLAN A

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

*Once you have been billed \$135 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 A 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 \$135 of Medicare-approved Amounts* Remainder of Medicare-approved Amounts	\$0 80% (Generally)	\$0 20% (Generally)	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$135 of Medicare-approved Amounts* Remainder of Medicare-approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment First \$135 of Medicare-approved Amounts* Remainder of Medicare-approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B Deductible) \$0

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.

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <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 	All but \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$1,068 (Part A Deductible) \$267 a day \$534 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 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 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 out-patient drugs and inpatient respite care	\$0	Balance

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

PLAN D

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

*Once you have been billed [\$135 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 D 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 \$135 of Medicare-approved Amounts* Remainder of Medicare-approved Amounts	\$0 80% (Generally)	\$0 20% (Generally)	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$135 of Medicare-approved Amounts* Remainder of Medicare-approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN D

(continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN D PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE-APPROVED SERVICES			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies 	100%	\$0	\$0
<ul style="list-style-type: none"> • Durable medical equipment 	\$0	\$0	\$135 (Part B Deductible)
<ul style="list-style-type: none"> • First \$135 of Medicare-approved Amounts* • 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			
<ul style="list-style-type: none"> • Benefit for each visit 	\$0	Actual Charges to \$40 a visit	Balance
<ul style="list-style-type: none"> • Number of visits covered (must be received within 8 weeks of last Medicare-approved visit) 	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
<ul style="list-style-type: none"> • Calendar year maximum 	\$0	\$1,600	

OTHER BENEFITS — NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN D 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			
<ul style="list-style-type: none"> • First \$250 each calendar year 	\$0	\$0	\$250
<ul style="list-style-type: none"> • Remainder of Charges 	\$0	80% to a lifetime maximum benefit of \$50,000	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.

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <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 	All but \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$1,068 (Part A Deductible) \$267 a day \$534 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 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 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 out-patient drugs and inpatient respite care	\$0	Balance

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

PLAN F

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

*Once you have been billed \$135 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 F 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 \$135 of Medicare-approved Amounts* Remainder of Medicare-approved Amounts	\$0 80% (Generally)	\$135 (Part B Deductible) 20% (Generally)	\$0 \$0
Part B Excess Charges (Above Medicare-approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$135 of Medicare-approved Amounts* Remainder of Medicare-approved Amounts	\$0 \$0 80%	All Costs \$135 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment First \$135 of Medicare-approved Amounts* Remainder of Medicare-approved Amounts	100% \$0 80%	\$0 \$135 (Part B Deductible) 20%	\$0 \$0 \$0

(continued)

PLAN F

(Continued)

OTHER BENEFITS — NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN F 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 or offers 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 thru 90th day 91st day and after: <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	All but \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$1,068 (Part A Deductible) \$267 a day \$534 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 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 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 out-patient drugs and inpatient respite care	\$0	Balance

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

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed \$135 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 or offers 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 Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$135 of Medicare-approved Amounts* Remainder of Medicare-approved Amounts	\$0 80% (Generally)	\$135 (Part B Deductible) 20% (Generally)	\$0 \$0
Part B Excess Charges (Above Medicare-approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$135 of Medicare-approved Amounts* Remainder of Medicare-approved Amounts	\$0 \$0 80%	All Costs \$135 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

HIGH DEDUCTIBLE PLAN F

(continued)

PARTS A & B

*Once you have been billed \$135 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 or offers 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
HOME HEALTH CARE MEDICARE-APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
<ul style="list-style-type: none"> First \$135 of Medicare-approved Amounts* Remainder of Medicare-approved Amounts 	\$0 80%	\$135 (Part B Deductible) 20%	\$0 \$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			
<ul style="list-style-type: none"> 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

Blue Cross and Blue Shield of Oklahoma

Outline Of Medicare Supplement Coverage — Cover Page: 1 of 2

Benefit Plan F *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. The information following the chart outlines Medicare Supplement Blue Plan65 *Select*, which closely aligns with Plan F. Pages 6 thru 8 explain your benefits for both Blue Plan65 *Select* Network Providers and Out-of-Network Providers.

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 (20% of Medicare-approved expenses).

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	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	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	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 Deductible
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	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	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare							Preventive Care NOT covered by Medicare

*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 benefits as Plans F and J after one has paid a calendar year \$2,000 deductible. Benefits from high deductible Plans F and J 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. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan's separate foreign emergency deductible. High Deductible Plan J is not currently available from Blue Cross and Blue Shield of Oklahoma.

Blue Cross and Blue Shield of Oklahoma

Outline Of Medicare Supplement Coverage – Cover Page: 2 of 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the Basic Benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits end 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits end 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	\$4,620 Out-of-Pocket Annual Limit***	\$2,310 Out-of-Pocket Annual Limit***

**Plans K and L provide for different cost-sharing for items and services than Plans A-J.

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your Provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

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.

BLUE PLAN65 <i>SELECT</i> PREMIUMS			
	<u>Monthly</u>	<u>Quarterly</u>	<u>Semiannually</u>
Age 65-69 (Enrolled in Medicare Part B Less than Six Months)*	\$109.90	\$329.70	\$ 659.40
Age 65-69 (Enrolled in Medicare Part B Six Months or Longer)	\$137.30	\$411.90	\$ 823.80
Age 70+ (Enrolled in Medicare Part B Less than Six Months)	\$151.10	\$453.30	\$ 906.60
Age 70+ Enrolled in Medicare Part B Six Months or Longer)	\$173.70	\$521.10	\$1,042.20

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 POLICY

If you find that you are not satisfied with your policy, you may return it to Blue Cross and Blue Shield of Oklahoma, P. O. Box 3283, Tulsa, Oklahoma 74102-3283. 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.

* Members who enroll at ages 65-69 and during the first six months following their enrollment in Medicare Part B are eligible for a four-year discount of 20% the first year of enrollment, 15% the second year, 10% the third year, and 5% the fourth year. The premiums shown reflect the 20% discount available for the first year of enrollment. Early enrollment discounts are available to members who enroll in Plan65 for the first time January 1, 2006 or later.

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 Oklahoma 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 medical and health history (if required). 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.

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. 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 \$1,068 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 \$135 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 service 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 \$1,068	\$1,068 (Part A Deductible)	\$ 0	\$ 0	\$1,068 (Part A Deductible)
61st thru 90th day	All but \$267 a day	\$267 a day	\$ 0	\$267 a day	\$ 0
91st day and after:					
•While using 60 lifetime reserve days	All but \$534 a day	\$534 a day	\$ 0	\$534 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 3 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 thru 100th day	All but \$133.50 a day	Up to \$133.50 a day	\$ 0	\$ 0	Up to \$133.50 a day
101st day and after	\$ 0	\$ 0	All Costs	\$ 0	All Costs
BLOOD					
First 3 pints	\$ 0	3 pints	\$ 0	3 pints	\$ 0
Additional amounts	100%	\$ 0	\$ 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	\$ 0	Balance

BLUE PLAN65 *SELECT* — PLAN F

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

*Once you have been billed \$135 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 \$135 of Medicare-approved Amounts*	\$0	\$135 (Part B Deductible)	\$ 0	\$ 0	\$135 (Part B Deductible)
Remainder of Medicare-approved Amounts	80% (Generally)	20% (Generally)	\$ 0	20% (Generally)	\$ 0
Part B Excess Charges (Above Medicare-approved Amounts)	\$ 0	100%	\$ 0	\$ 0	All Costs
BLOOD					
First 3 pints	\$ 0	All Costs	\$ 0	All Costs	\$ 0
Next \$135 of Medicare-approved Amounts*	\$ 0	\$135 (Part B Deductible)	\$ 0	\$ 0	\$135 (Part B Deductible)
Remainder of Medicare-approved Amounts	80%	20%	\$ 0	20%	\$ 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 \$135 of Medicare-approved Amounts*	\$ 0	\$135 (Part B Deductible)	\$ 0	\$ 0	\$135 (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



BlueCross BlueShield of Oklahoma

www.bcbsok.com

TULSA

1215 S. Boulder

P.O. Box 3283

Tulsa, OK 74102-3283

(918) 560-3500

OKLAHOMA CITY

3401 NW 63rd

P.O. Box 60545

Oklahoma City, OK 73146-0545

(405) 841-9525