of Tennessee

BlueElite℠

Outline of Medicare Supplement Coverage Benefits

Plans A, B, C, D, F, G, K, L, M and N*

*** BlueCross BlueShield of Tennessee only offers Plans A, C, D, F, G and N.**

Benefit Chart of Medicare Supplement Plans Sold with an effective date of coverage on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan A available. Some plans may not be available in your state.

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, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	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 $5,240 paid at 100% after limit reached	Out-of-pocket limit $2,620 paid at 100% after limit reached		

** Plan F also has an option called a high-deductible Plan F. BlueCross BlueShield of Tennessee does not offer high-deductible Plan F. This high-deductible plan pays the same benefits as Plan F after one has paid a calendar year deductible of $2,300 in 2019. Benefits from high-deductible Plan F will not begin until out-of-pocket expenses exceed $2,300 in 2019. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible. BlueCross BlueShield of Tennessee does not sell plans B, high-deductible F, K, L or M.

BlueElite Monthly Premiums Effective 6/1/2018

Premiums may be subject to change.[1]

	Female Non-Tobacco[2]					
Attained Age	**Plan A**	**Plan C**	**Plan D**	**Plan F**	**Plan G**	**Plan N**
65	$64.60	$131.79	$109.05	$138.16	$128.99	$98.15
66	$68.90	$140.57	$116.31	$147.36	$137.59	$104.68
67	$73.49	$149.93	$124.06	$157.17	$146.75	$111.66
68	$78.10	$159.36	$131.86	$167.06	$155.98	$118.68
69	$82.74	$168.77	$139.63	$176.92	$165.19	$125.67
70	$87.36	$178.22	$147.50	$186.83	$174.44	$132.75
71	$91.95	$187.65	$155.28	$196.71	$183.67	$139.75
72	$96.59	$197.04	$163.06	$206.56	$192.86	$146.75
73	$101.16	$206.40	$170.85	$216.37	$202.02	$153.76
74	$105.80	$215.89	$178.65	$226.32	$211.31	$160.78
75	$109.89	$224.24	$185.57	$235.07	$219.48	$167.01
76	$115.03	$234.68	$194.18	$246.02	$229.70	$174.76
77	$119.65	$244.12	$202.01	$255.92	$238.94	$181.81
78	$123.90	$252.76	$209.15	$264.97	$247.40	$188.24
79	$127.77	$260.71	$215.77	$273.30	$255.18	$194.20
80	$131.37	$268.09	$221.83	$281.04	$262.40	$199.65
81	$134.80	$274.98	$227.54	$288.26	$269.14	$204.79
82	$137.93	$281.42	$232.86	$295.02	$275.45	$209.58
83	$140.92	$287.46	$237.90	$301.34	$281.36	$214.11
84	$143.66	$293.20	$242.61	$307.37	$286.98	$218.35
85	$146.36	$298.59	$247.09	$313.02	$292.26	$222.38
86	$148.85	$303.58	$251.35	$318.25	$297.14	$226.21
87	$151.24	$308.60	$255.38	$323.51	$302.05	$229.84
88	$153.51	$313.27	$259.25	$328.41	$306.62	$233.33
89	$155.72	$317.72	$262.90	$333.08	$310.98	$236.61
90	$157.83	$321.99	$266.43	$337.54	$315.15	$239.79
91	$159.80	$326.07	$269.84	$341.82	$319.15	$242.85
Under 65[3]	$608.82	$1,119.82	$1,027.78	$1,173.93	$1,096.06	$925.00

[1] Monthly premiums will increase by 10% for enrollees who move outside of the state of Tennessee.

[2] This chart shows monthly premiums for BlueElite Medicare Supplement plans when applying during a Guaranteed Issue Period or Medigap Open Enrollment Period.

[3] Eligible for and enrolled in Medicare by reason of disability or end stage renal disease.

BlueElite Monthly Premiums Effective 6/1/2018

Premiums may be subject to change.[1]

	Male Non-Tobacco[2]					
Attained Age	**Plan A**	**Plan C**	**Plan D**	**Plan F**	**Plan G**	**Plan N**
65	$70.22	$143.26	$118.55	$150.18	$140.22	$106.69
66	$74.88	$152.80	$126.44	$160.18	$149.56	$113.80
67	$79.87	$162.97	$134.86	$170.85	$159.51	$121.38
68	$84.90	$173.23	$143.34	$181.60	$169.56	$129.00
69	$89.95	$183.44	$151.80	$192.30	$179.55	$136.62
70	$94.95	$193.73	$160.34	$203.09	$189.62	$144.31
71	$99.95	$203.98	$168.79	$213.84	$199.65	$151.91
72	$105.00	$214.20	$177.24	$224.55	$209.66	$159.52
73	$109.96	$224.37	$185.71	$235.21	$219.61	$167.14
74	$115.02	$234.67	$194.19	$246.01	$229.69	$174.77
75	$119.45	$243.75	$201.71	$255.53	$238.58	$181.54
76	$125.03	$255.10	$211.08	$267.43	$249.69	$189.97
77	$130.05	$265.37	$219.60	$278.19	$259.74	$197.64
78	$134.69	$274.75	$227.36	$288.03	$268.92	$204.62
79	$138.89	$283.40	$234.54	$297.09	$277.39	$211.09
80	$142.82	$291.41	$241.13	$305.49	$285.23	$217.02
81	$146.53	$298.90	$247.34	$313.34	$292.56	$222.61
82	$149.93	$305.91	$253.12	$320.69	$299.42	$227.81
83	$153.17	$312.48	$258.60	$327.58	$305.85	$232.74
84	$156.16	$318.72	$263.71	$334.12	$311.95	$237.34
85	$159.09	$324.57	$268.58	$340.25	$317.69	$241.72
86	$161.80	$329.99	$273.21	$345.93	$322.99	$245.89
87	$164.41	$335.45	$277.60	$351.65	$328.33	$249.84
88	$166.87	$340.52	$281.82	$356.98	$333.30	$253.63
89	$169.29	$345.38	$285.78	$362.06	$338.05	$257.20
90	$171.58	$350.02	$289.63	$366.93	$342.59	$260.66
91	$173.71	$354.45	$293.30	$371.58	$346.93	$263.97
Under 65[3]	$661.79	$1,217.30	$1,117.21	$1,276.12	$1,191.48	$1,005.49

[1] Monthly premiums will increase by 10% for enrollees who move outside of the state of Tennessee.

[2] This chart shows monthly premiums for BlueElite Medicare Supplement plans when applying during a Guaranteed Issue Period or Medigap Open Enrollment Period.

[3] Eligible for and enrolled in Medicare by reason of disability or end stage renal disease.

BlueElite Monthly Premiums Effective 6/1/2018

Premiums may be subject to change.[1]

	Female Tobacco User[2]					
Attained Age	**Plan A**	**Plan C**	**Plan D**	**Plan F**	**Plan G**	**Plan N**
65	$71.06	$144.97	$119.96	$151.98	$141.89	$107.97
66	$75.79	$154.63	$127.95	$162.10	$151.35	$115.15
67	$80.84	$164.92	$136.47	$172.89	$161.43	$122.83
68	$85.91	$175.30	$145.05	$183.77	$171.58	$130.55
69	$91.01	$185.65	$153.59	$194.61	$181.71	$138.24
70	$96.10	$196.04	$162.25	$205.51	$191.88	$146.03
71	$101.15	$206.42	$170.81	$216.38	$202.04	$153.73
72	$106.25	$216.74	$179.37	$227.22	$212.15	$161.43
73	$111.28	$227.04	$187.94	$238.01	$222.22	$169.14
74	$116.38	$237.48	$196.52	$248.95	$232.44	$176.86
75	$120.88	$246.66	$204.13	$258.58	$241.43	$183.71
76	$126.53	$258.15	$213.60	$270.62	$252.67	$192.23
77	$131.62	$268.53	$222.21	$281.51	$262.83	$199.99
78	$136.29	$278.04	$230.07	$291.47	$272.14	$207.06
79	$140.55	$286.78	$237.35	$300.63	$280.70	$213.62
80	$144.51	$294.90	$244.01	$309.14	$288.64	$219.62
81	$148.28	$302.48	$250.29	$317.09	$296.05	$225.27
82	$151.72	$309.56	$256.15	$324.52	$303.00	$230.54
83	$155.01	$316.21	$261.69	$331.47	$309.50	$235.52
84	$158.03	$322.52	$266.87	$338.11	$315.68	$240.19
85	$161.00	$328.45	$271.80	$344.32	$321.49	$244.62
86	$163.74	$333.94	$276.49	$350.08	$326.85	$248.83
87	$166.36	$339.46	$280.92	$355.86	$332.26	$252.82
88	$168.86	$344.60	$285.18	$361.25	$337.28	$256.66
89	$171.29	$349.49	$289.19	$366.39	$342.08	$260.27
90	$173.61	$354.19	$293.07	$371.29	$346.67	$263.77
91	$175.78	$358.68	$296.82	$376.00	$351.07	$267.14
Under 65[3]	$669.70	$1,231.80	$1,130.56	$1,291.32	$1,205.67	$1,017.50

[1] Monthly premiums will increase by 10% for enrollees who move outside of the state of Tennessee.

[2] This chart shows monthly premiums for BlueElite Medicare Supplement plans for tobacco users not applying during a Guaranteed Issue Period or Medigap Open Enrollment Period.

[3] Eligible for and enrolled in Medicare by reason of disability or end stage renal disease.

BlueElite Monthly Premiums Effective 6/1/2018

Premiums may be subject to change.[1]

	Male Tobacco User[2]					
Attained Age	**Plan A**	**Plan C**	**Plan D**	**Plan F**	**Plan G**	**Plan N**
65	$77.24	$157.59	$130.41	$165.20	$154.24	$117.36
66	$82.37	$168.08	$139.08	$176.20	$164.52	$125.18
67	$87.86	$179.27	$148.35	$187.94	$175.46	$133.52
68	$93.39	$190.55	$157.67	$199.76	$186.52	$141.90
69	$98.95	$201.78	$166.98	$211.53	$197.51	$150.28
70	$104.45	$213.10	$176.37	$223.40	$208.58	$158.74
71	$109.95	$224.38	$185.67	$235.22	$219.62	$167.10
72	$115.50	$235.62	$194.96	$247.01	$230.63	$175.47
73	$120.96	$246.81	$204.28	$258.73	$241.57	$183.85
74	$126.52	$258.14	$213.61	$270.61	$252.66	$192.25
75	$131.40	$268.13	$221.88	$281.08	$262.44	$199.69
76	$137.53	$280.61	$232.19	$294.17	$274.66	$208.97
77	$143.06	$291.91	$241.56	$306.01	$285.71	$217.40
78	$148.16	$302.23	$250.10	$316.83	$295.81	$225.08
79	$152.78	$311.74	$257.99	$326.80	$305.13	$232.20
80	$157.10	$320.55	$265.24	$336.04	$313.75	$238.72
81	$161.18	$328.79	$272.07	$344.68	$321.82	$244.87
82	$164.92	$336.50	$278.43	$352.76	$329.36	$250.59
83	$168.49	$343.73	$284.46	$360.34	$336.44	$256.01
84	$171.78	$350.59	$290.08	$367.53	$343.15	$261.07
85	$175.00	$357.03	$295.44	$374.28	$349.46	$265.89
86	$177.98	$362.99	$300.53	$380.52	$355.29	$270.48
87	$180.85	$369.00	$305.36	$386.82	$361.16	$274.82
88	$183.56	$374.57	$310.00	$392.68	$366.63	$278.99
89	$186.22	$379.92	$314.36	$398.27	$371.86	$282.92
90	$188.74	$385.02	$318.59	$403.62	$376.85	$286.73
91	$191.08	$389.90	$322.63	$408.74	$381.62	$290.37
Under 65[3]	$727.97	$1,339.03	$1,228.93	$1,403.73	$1,310.63	$1,106.04

[1] Monthly premiums will increase by 10% for enrollees who move outside of the state of Tennessee.

[2] This chart shows monthly premiums for BlueElite Medicare Supplement plans for tobacco users not applying during a Guaranteed Issue Period or Medigap Open Enrollment Period.

[3] Eligible for and enrolled in Medicare by reason of disability or end stage renal disease.

PREMIUM INFORMATION

BlueCross BlueShield of Tennessee can only raise your premium if we raise the premium for all policies like yours in the state of Tennessee. Your premium rate is based on your age as of June 1 each year, and it increases annually as you move into the next age category. If you are not yet 65 but will be on your initial effective date, your premium rate will be the age 65 rate. If you are over 65 and enrolling or changing plans, your premium rate is based on your age as of June 1 on or before your initial effective date. Your rate will increase by 10% if you move outside the state of Tennessee. Other than for age or moving out of the state, BlueCross BlueShield of Tennessee will only adjust your rate if rates are adjusted for all policies like yours. Any rate adjustment will be made at the same time for all BlueElite customers who have the same policy.

Disclosures

Use this outline to compare benefits and premiums among policies. This BlueElite Outline of Coverage has been updated to reflect Original Medicare's 2019 out-of-pocket expenses.

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 the rights and duties of both you and BlueCross BlueShield of Tennessee.

Right to Return Policy

If you find that you are not satisfied with your policy, you may return it to:

BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402

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 (less any benefits provided).

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 BlueCross BlueShield of Tennessee nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult the *Medicare and You* 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. BlueCross BlueShield of Tennessee may cancel your policy or 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.

No Health Review

A health review is not required for BlueCross BlueShield of Tennessee Medicare Supplement plans if you enroll within the first six months after you reach age 65 and enroll in Medicare Part B, or in other situations as required by law.

Limitations and Exclusions

Unless otherwise specifically noted in your policy, BlueCross BlueShield of Tennessee Medicare Supplement plans do not provide benefits for any of the following:

+ Services and supplies not covered by Medicare, except those specifically included under the plan you select.
+ Any expense that is paid by Medicare.
+ Hospital stays beginning or medical expenses incurred during the first six months of coverage if they are caused by what is considered a pre-existing condition. A condition is considered pre-existing if medical advice was given or treatment recommended by or received from a physician within six months prior to the insurance effective date. All or part of this six-month pre-existing condition waiting period can be waived if you have creditable coverage.*

* Does not apply if you are in your Medigap Open Enrollment Period or Guaranteed Issue Period. Please refer to your policy for more information.

* 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.

Plan A Medicare (Part A)

Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$0	$1,364 (Part A deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $682 a day	$682 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 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $170.50 a day	$0	Up to $170.50 a day
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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 outpatient drugs and inpatient respite care	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.

Plan A Medicare (Part B)

Medical Services – Per Calendar Year

* Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $185 of Medicare Approved Amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$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 $185 of Medicare Approved Amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

* 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.

Plan C Medicare (Part A)

Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $682 a day	$682 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 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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 outpatient drugs and inpatient respite care	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.

Plan C Medicare (Part B)

Medical Services – Per Calendar Year

* Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$185 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $185 of Medicare Approved Amounts*	$0	$185 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests For Diagnostic Services	100%	0%	0%

* Once you have been billed $185 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.

Plan C 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 $185 of Medicare Approved Amounts*	$0	$185 (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

Plan D 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	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $682 a day	$682 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 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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 outpatient drugs and inpatient respite care	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.

* Once you have been billed $185 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.

Plan D Medicare (Part B)

Medical Services – Per 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $185 of Medicare Approved Amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests For Diagnostic Services	100%	0%	0%

Plan D Medicare (Parts A&B)

* Once you have been billed $185 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
Home Health Care Medicare Approved Services Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment			
First $185 of Medicare Approved Amounts*	$0	$0	$185 (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

* 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.

Plan F Medicare (Part A)

Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $682 a day	$682 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 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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 outpatient drugs and inpatient respite care	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.

Plan F Medicare (Part B)

Medical Services – Per Calendar Year

* Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$185 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $185 of Medicare Approved Amounts*	$0	$185 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests For Diagnostic Services	100%	0%	0%

* Once you have been billed $185 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.

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 $185 of Medicare Approved Amounts*	$0	$185 (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

Plan G 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	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $682 a day	$682 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 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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 outpatient drugs and inpatient respite care	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.

* Once you have been billed $185 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.

Plan G Medicare (Part B)

Medical Services – Per 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $185 of Medicare Approved Amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests For Diagnostic Services	100%	0%	0%

Plan G Medicare (Parts A&B)

* Once you have been billed $185 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
Home Health Care Medicare Approved Services Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable Medical Equipment			
First $185 of Medicare Approved Amounts*	$0	$0	$185 (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

* 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.

Plan N Medicare (Part A)

Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $682 a day	$682 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 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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 outpatient drugs and inpatient respite care	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.

Plan N Medicare (Part B)

Medical Services – Per Calendar Year

* Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $185 of Medicare Approved Amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Clinical Laboratory Services			
Tests For Diagnostic Services	100%	0%	0%

Note: Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.

* Once you have been billed $185 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.

Plan N 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

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

of Tennessee

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross), including its subsidiaries Security Care, Inc. and Volunteer State Health Plan, Inc. also doing business as BlueCare Tennessee, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact Member Service at the number on the back of your Member ID card or call 1-800-553-8158 (TTY: 711). From Oct. 1 to March 31, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From April 1 to Sept. 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Our automated phone system may answer your call outside of these hours and during holidays.

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact Member Service at the number on the back of your Member ID card or call 1-800-553-8158 (TTY: 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD), 8:30 a.m. to 8 p.m. ET. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Multi Language Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-800-553-8158 (TTY: 711).

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-800-553-8158 (TTY:711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-553-8158 (TTY:711) 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-800-553-8158 (TTY:711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-553-8158 (TTY: 711) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-553-8158 (ATS : 711).

ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-800-553-8158 (TTY: 711).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-553-8158 (መስማት ለተሳናቸው: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: 1-800-553-8158 (TTY: 711).

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-553-8158 (TTY: 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
800-553-8158 (TTY:711) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-553-8158 (TTY:711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-800-553-8158 (TTY: 711) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-553-8158 (телетайп: 711).

توجه: اگر به زبان فارسی صحبت می کنید خدمات زبان و ترجمه به صورت رایگان برایتان فراهم می گردد. با 1-800-553-8158 (TTY:771) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Rele 1-800-553-8158 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.
Zadzwoń pod numer 1-800-553-8158 (TTY: 711).

ATENÇÃO: se fala português, encontram-se disponíveis serviços linguísticos grátis.
Ligue para 1-800-553-8158 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-553-8158 (TTY: 711).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-553-8158 (TTY: 711).

Notes

For more information, please call
1-800-247-8510
8 a.m. - 6 p.m. ET
Monday - Friday
TTY users call 711 or visit

bcbstmedicare.com

of Tennessee

1 Cameron Hill Circle | Chattanooga, TN 37402 | bcbstmedicare.com