

Basic Medicare Select: Senior Gold Plan
Basic Medicare Supplement: Basic Medicare Blue Plan
Extended Basic Medicare Supplement: Extended Basic Blue Plan
Standard Medicare Supplement Plan with 50 Percent Coverage (Plan K)
Standard Medicare Supplement Plan with 75 Percent Coverage (Plan L)

Blue Cross and Blue Shield of Minnesota (Blue Cross) offers five (5) policies that fill in “gaps” to supplement your Medicare coverage. **Senior Gold** is a Basic Medicare Select plan. Select plans are standardized supplements, but Select plan subscribers are required to use specific or preferred providers for certain benefits to be covered in Minnesota. Except for emergency care, if Select plan subscribers do not use plan providers for certain benefits, Blue Cross is not required to pay benefits. Select plan providers are available within Minnesota, and in all North Dakota, South Dakota, Iowa and Wisconsin counties that border Minnesota. Our **Basic Medicare Blue, Extended Basic Blue, Medicare Supplement Plan K** and **Medicare Supplement Plan L** are standard Medigap Supplement policies where coverage is available with any provider that participates in Medicare. Please consult your contract for details of coverage. Contact your local Social Security office or consult the Medicare Handbook for details of Medicare coverage.

As you read through this summary, please remember the following:

1. For some services, Medicare determines if the services available on your Medicare Supplement or Select contract are eligible for coverage.
2. It is possible for Medicare to allow a charge, but not pay for it. Whether your Blue Cross contract pays for it depends upon the contract language. Please read your contract carefully.
3. For most services, if Medicare denies a charge, we must deny it, too. There are exceptions. Some benefits that are required by Minnesota state law are included in your supplement or Select contract, even though Medicare does not cover them.
4. **THESE CONTRACTS DO NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THESE CONTRACTS DO NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DO NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR CONTRACT CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR CONTRACT.**
5. Your contract will not be cancelled/non-renewed because of a deterioration of your health. This contract is guaranteed renewable at a rate that does not take into account your individual claims experience or changes in your health status that occur after the initial issuance of coverage. You accept your renewal by paying monthly premiums when due. Rates are based on information you provide indicating whether you use tobacco products. Refer to Section V for current rates.
6. Your contract may be cancelled/non-renewed for nonpayment of premium.
7. Your contract may be allowed to lapse at your request within 90 days of your enrollment if you enroll in the Medicaid program. You may reinstate Medicare Supplement or Select coverage if your Medicaid benefits end within 24 months from the time you first suspend your Medicare Supplement or Medicare Select coverage.
8. If you are enrolled in Medicare because you are disabled and are covered under a group health plan through your employer, you may not need this Medicare Supplement or Select contract. The benefits and charges you receive under this Medicare Supplement or Select contract may be suspended during your enrollment in a group health plan. You must request this suspension in writing by contacting Blue Cross. When your group health plan coverage ends, your Medicare Supplement or Select contract will be reactivated if you request us to do so in writing within 90 days of your group plan coverage termination.

9. These contracts have a minimum anticipated loss ratio of 65%. On average, you may expect that \$65 of every \$100 in premium will be returned as benefits over the life of your contract.
10. If you receive care within Minnesota or in any county which borders Minnesota, Select members must use providers who participate with Blue Cross and Blue Shield of Minnesota for certain benefits to be covered, while Supplement members may see any provider that participates in Medicare. If you receive care outside of Minnesota, claims are paid on the same basis as when you are in Minnesota if you see a provider who participates with Medicare. See your contract for specifics.
11. The State of Minnesota provides counseling services through the Senior LinkAge Line to provide advice concerning the purchase of Medicare Supplement policies and enrollment under Medicaid. You can contact the Senior LinkAge Line at 1-800-333-2433 and ask for a Health Insurance Counselor.
12. Contact the Minnesota Department of Commerce at 651-539-1600 or 1-800-657-3602 (MN only outside metro area) for information about other medical insurance products currently available in Minnesota.

I. SUMMARY OF BENEFITS Original Medicare	Basic Medicare Select: (Senior Gold) Coverage
Inpatient Hospital Services <ul style="list-style-type: none"> • 60 days of hospital inpatient care at 100% after your Medicare Part A deductible • Days 61-90 and your 60 lifetime reserve days at 100% after a daily Part A coinsurance amount 	Inpatient Hospital Services <ul style="list-style-type: none"> • Optional coverage of Medicare Part A deductible available • Medicare Part A coinsurance • Medicare-eligible services in full after Medicare benefits are exhausted You pay Part A deductible unless optional coverage is selected
Skilled Nursing Care <ul style="list-style-type: none"> • The first 20 days at 100% • Days 21-100 at 100% after Part A daily coinsurance amount • NO COVERAGE after the 100th day 	Skilled Nursing Care <ul style="list-style-type: none"> • Medicare Part A coinsurance You pay all charges after the 100th day
Hospice <ul style="list-style-type: none"> • You pay part of the cost for outpatient drugs and inpatient respite care • You must get care from a Medicare-certified hospice 	Hospice <ul style="list-style-type: none"> • Covered in full by Medicare • Any remaining Medicare-eligible charges covered in full
Home Health Care <ul style="list-style-type: none"> • 100% 	Home Health Care <ul style="list-style-type: none"> • Covered in full by Medicare • Any remaining Medicare-eligible charges covered in full You pay nothing
Emergency Services <ul style="list-style-type: none"> • Same as hospital and medical services • 80% of Medicare approved charges after annual Part B deductible. Not covered outside the U.S. except under limited circumstances 	Emergency Services <ul style="list-style-type: none"> • Optional coverage for Part B deductible available • Optional rider for remaining balances on nonassigned claims • 20% of Medicare's approved charge You pay Part B deductible and any remaining charges unless optional riders are selected
Medical Services, Outpatient Services and Durable Medical Equipment <ul style="list-style-type: none"> • 80% of Medicare's approved charges after annual Part B deductible • Cancer screening services and diabetic supplies 	Medical Services, Outpatient Services and Durable Medical Equipment <ul style="list-style-type: none"> • Optional coverage for Part B deductible available • Optional rider for remaining balances on nonassigned claims • 20% of Medicare's approved charge You pay Part B deductible and any remaining charges unless optional riders are selected
Foreign Medical Services <ul style="list-style-type: none"> • Not covered, except under limited circumstances 	Foreign Medical Services <ul style="list-style-type: none"> • 80% of eligible services for emergency treatment You pay any remaining charges
Preventive Services (screening exams) <ul style="list-style-type: none"> • 100% of Medicare's approved charges for bone mass measurement, colorectal screening exams, immunizations, pap smears and pelvic exams, prostate cancer screening exam; Welcome to Medicare exam and Annual Wellness Visits 	Preventive Services (Optional Benefit) <ul style="list-style-type: none"> • Annual routine physical exam and some routine screenings are covered in full by Medicare. Optional benefit covers up to \$120 benefit per year for non-Medicare covered services such as annual eye exams, hearing screenings, and other routine screenings at intervals listed in the contract You pay any remaining charges

Original Medicare	Basic Medicare Supplement (Basic Medicare Blue) Coverage:
Inpatient Hospital Services <ul style="list-style-type: none"> • 60 days of hospital inpatient care at 100% after your Medicare Part A deductible • Days 61-90 and your 60 lifetime reserve days at 100% after a daily Part A coinsurance amount 	Inpatient Hospital Services <ul style="list-style-type: none"> • Optional coverage of Medicare Part A deductible available • Medicare Part A coinsurance • Medicare-eligible services in full after Medicare benefits are exhausted You pay Part A deductible unless optional coverage is selected
Skilled Nursing Care <ul style="list-style-type: none"> • The first 20 days at 100% • Days 21-100 at 100% after Part A daily coinsurance amount • NO COVERAGE after the 100th day 	Skilled Nursing Care <ul style="list-style-type: none"> • Medicare Part A coinsurance You pay all charges after the 100th day
Hospice <ul style="list-style-type: none"> • You pay part of the cost for outpatient drugs and inpatient respite care • You must get care from a Medicare-certified hospice 	Hospice <ul style="list-style-type: none"> • Covered in full by Medicare • Any remaining Medicare-eligible charges covered in full You pay nothing
Home Health Care <ul style="list-style-type: none"> • 100% 	Home Health Care <ul style="list-style-type: none"> • Covered in full by Medicare • Any remaining Medicare-eligible charges covered in full You pay nothing
Emergency Services <ul style="list-style-type: none"> • Same as hospital and medical services • 80% of Medicare approved charges after annual Part B deductible. Not covered outside the U.S. except under limited circumstances 	Emergency Services <ul style="list-style-type: none"> • Optional coverage for Part B deductible available • Optional rider for remaining balances on nonassigned claims • 20% of Medicare's approved charge You pay Part B deductible and any remaining charges unless optional coverage is selected
Medical Services, Outpatient Services and Durable Medical Equipment <ul style="list-style-type: none"> • 80% of Medicare's approved charges after annual Part B deductible • Cancer screening services • Diabetic supplies 	Medical Services, Outpatient Services and Durable Medical Equipment <ul style="list-style-type: none"> • Optional coverage for Part B deductible available • Optional rider for remaining balances on nonassigned claims • 20% of Medicare's approved charge You pay Part B deductible and any remaining charges unless optional coverage is selected
Foreign Medical Services <ul style="list-style-type: none"> • Not covered, except under limited circumstances 	Foreign Medical Services <ul style="list-style-type: none"> • 80% of eligible services for emergency treatment You pay any remaining charges
Preventive Services (screening exams) <ul style="list-style-type: none"> • 100% of Medicare's approved charges for bone mass measurement, colorectal screening exams, immunizations, pap smears and pelvic exams, prostate cancer screening exam; Welcome to Medicare exam and Annual Wellness Visits 	Preventive Services (Optional Benefit) <ul style="list-style-type: none"> • Annual routine physical exam and some routine screenings are covered in full by Medicare. Optional benefit covers up to \$120 benefit per year for non-Medicare covered services such as annual eye exams, hearing screenings, and other routine screenings at intervals listed in the contract You pay any remaining charges

Extended Basic Medicare Supplement (Extended Basic Blue) Coverage:

This product covers 100% of all eligible charges after a member total annual out-of-pocket maximum of \$1,000 for eligible services.

Original Medicare

Inpatient Hospital Services

- 60 days of hospital inpatient care at 100% after your Medicare Part A deductible
- Days 61-90 and your 60 lifetime reserve days at 100% after a daily Part A coinsurance amount

Skilled Nursing Care

- The first 20 days at 100%
- Days 21-100 at 100% after Part A daily coinsurance amount
- NO COVERAGE after the 100th day

Hospice

- You pay part of the cost for outpatient drugs and inpatient respite care
- You must get care from a Medicare-certified hospice

Home Health Care

- 100%

Emergency Services

- Same as hospital and medical services
- 80% of Medicare approved charges after annual Part B deductible. Not covered outside the U.S. except under limited circumstances

Medical Services, Outpatient Services and Durable Medical Equipment

- 80% of Medicare's approved charges after annual Part B deductible
- Cancer screening services
- Diabetic supplies

Foreign Medical Services

- Not covered, except under limited circumstances

Preventive Services (screening exams)

- 100% of Medicare's approved charges for bone mass measurement, colorectal screening exams, immunizations, pap smears and pelvic exams, prostate cancer screening exam; Welcome to Medicare exam and Annual Wellness Visits

Inpatient Hospital Services

- Medicare Part A deductible
 - Medicare Part A coinsurance
 - Medicare-eligible services in full after Medicare are exhausted
- You pay nothing**

Skilled Nursing Care

- Medicare Part A coinsurance
 - 80% for eligible charges in days 101-120
- You pay 20% of eligible charges for days 101 through 120, then you pay all charges**

Hospice

- Covered in full by Medicare
 - Any remaining Medicare-eligible charges covered in full
- You pay nothing**

Home Health Care

- Covered in full by Medicare
- You pay nothing**

Emergency Services

- Part B deductible; 20% of Medicare's approved charge and 80% of the remaining eligible charges
 - Some extended benefits up to 80% of Medicare-eligible charges
- You pay any remaining charges**

Medical Services, Outpatient Services and Durable Medical Equipment

- Part B deductible; 20% of Medicare's approved charge and 80% of the remaining eligible charges
 - Some extended benefits up to 80% of Medicare-eligible charges
- You pay any remaining charges**

Foreign Medical Services

- 80% of eligible services
- You pay any remaining charges**

Preventive Services (Included Benefit)

- Annual routine physical exam and some routine screenings are covered in full by Medicare.
- Benefit covers up to \$120 benefit per year for non-Medicare covered services such as annual eye exams, hearing screenings, and other routine screenings.**
- You pay any remaining charges**

Original Medicare

Inpatient Hospital Services

- 60 days of hospital inpatient care at 100% after your Medicare Part A deductible
- Days 61-90 and your 60 lifetime reserve days at 100% after a daily Part A coinsurance amount

Skilled Nursing Care

- The first 20 days at 100%
- Days 21-100 at 100% after Part A daily coinsurance amount
- NO COVERAGE after the 100th day

Hospice

- You pay part of the cost for outpatient drugs and inpatient respite care
- You must get care from a Medicare-certified hospice

Home Health Care

- 100%

Emergency Services

- Same as hospital and medical services
- 80% of Medicare approved charges after annual Part B deductible. Not covered outside the U.S. except under limited circumstances

Medical Services, Outpatient Services and Durable Medical Equipment

- 80% of Medicare's approved charges after annual Part B deductible
- Cancer screening services
- Diabetic supplies

Foreign Medical Services

- Not covered, except under limited circumstances

Preventive Services (screening exams)

- 100% of Medicare's approved charges for bone mass measurement, colorectal screening exams, immunizations, pap smears and pelvic exams, prostate cancer screening exam; Welcome to Medicare exam and Annual Wellness Visits

Medicare Supplement Plan with 50 Percent Coverage (Plan K):

Hospital Services

- 50%* of Medicare Part A deductible
- 100% of Medicare Part A coinsurance
- Medicare-eligible services in full after Medicare benefits are exhausted, subject to a lifetime maximum of an additional 365 days

Skilled Nursing Care

- 50%* of Medicare Part A coinsurance
- You pay all charges after the 100th day of Skilled Nursing Care

Hospice

- 50%* of Medicare coinsurance or copayments

Home Health Care

- Covered in full by Medicare

Emergency Services

- 50%* of Medicare Part B cost sharing
- 50%* for the first three (3) pints of blood, 100% after that
- You pay the Part B deductible
- You pay any charges above Medicare's approved amount for nonassigned claims

Medical Services, Outpatient Services and Durable Medical Equipment

- 50%* of Medicare Part B cost sharing
- 50%* for the first three (3) pints of blood, 100% after that
- You pay the Part B deductible
- You pay any charges above Medicare's approved amount for nonassigned claims

Foreign Medical Services

- NO COVERAGE

Preventive Services

- 100% of Medicare Part B cost sharing for Medicare Part B eligible preventive services
- 100% of cost sharing for cancer screening procedures at intervals listed in the contract

* There is a \$4,940 in 2014 annual out-of-pocket maximum after which eligible expenses are paid at 100%. This out-of-pocket amount may be adjusted for inflation annually.

Original Medicare

Inpatient Hospital Services

- 60 days of hospital inpatient care at 100% after your Medicare Part A deductible
- Days 61-90 and your 60 lifetime reserve days at 100% after a daily Part A coinsurance amount

Skilled Nursing Care

- The first 20 days at 100%
- Days 21-100 at 100% after Part A daily coinsurance amount
- NO COVERAGE after the 100th day

Hospice

- You pay part of the cost for outpatient drugs and inpatient respite care
- You must get care from a Medicare-certified hospice

Home Health Care

- 100%

Emergency Services

- Same as hospital and medical services
- 80% of Medicare approved charges after annual Part B deductible. Not covered outside the U.S. except under limited circumstances

Medical Services, Outpatient Services and Durable Medical Equipment

- 80% of Medicare's approved charges after annual Part B deductible
- Cancer screening services
- Diabetic supplies

Foreign Medical Services

- Not covered, except under limited circumstances

Preventive Services (screening exams)

- 100% of Medicare's approved charges for bone mass measurement, colorectal screening exams, immunizations, pap smears and pelvic exams, prostate cancer screening exam; Welcome to Medicare exam and Annual Wellness Visits

Medicare Supplement Plan with 75 Percent Coverage (Plan L):

Hospital Services

- 75%* of Medicare Part A deductible
- 100% of Medicare Part A coinsurance
- Medicare-eligible services in full after Medicare benefits are exhausted, subject to a lifetime maximum of an additional 365 days

Skilled Nursing Care

- 75%* of Medicare Part A coinsurance
- You pay all charges after the 100th day of Skilled Nursing Care

Hospice

- 75%* of Medicare coinsurance or copayments

Home Health Care

- Covered in full by Medicare

Emergency Services

- 75%* of Medicare Part B cost sharing
- 75%* for the first three (3) pints of blood, 100% after that
- You pay the Part B deductible
- You pay any charges above Medicare's approved amount for nonassigned claims

Medical Services, Outpatient Services and Durable Medical Equipment

- 75%* of Medicare Part B cost sharing
- 75%* for the first three (3) pints of blood, 100% after that
- You pay the Part B deductible
- You pay any charges above Medicare's approved amount for nonassigned claims

Foreign Medical Services

- NO COVERAGE

Preventive Services

- 100% of Medicare Part B cost sharing for Medicare Part B eligible preventive services
- 100% of cost sharing for cancer screening procedures at intervals listed in the contract

*There is a \$2,470 in 2014 annual out-of-pocket maximum after which eligible expenses are paid at 100%. This out-of-pocket amount may be adjusted for inflation annually.

II. SUMMARY OF ADDITIONAL BENEFITS

There are some benefits on your contract that expand the coverage Medicare allows, or provide coverage that Medicare does not give or does not allow. These vary among our products. This is a general list of those benefits. Please read your contract language carefully to determine specific benefits and coverage.

Benefits That Broaden Medicare Coverage

Skilled Nursing Home Care: Coverage is furnished for nursing home care in coordination with Medicare.

- Basic Medicare Select (Senior Gold): Medicare limit 100 days
- Extended Basic Medicare Supplement (Extended Basic Blue): 120 days
- Basic Medicare Supplement (Basic Medicare Blue, Plan K and Plan L): Medicare limit 100 days

Home Health Care: Coverage is furnished for home care in coordination with Medicare.

- Basic Medicare Select (Senior Gold): Medicare Limits
- Extended Basic Medicare Supplement (Extended Basic Blue): 180 additional visits for skilled home health care.
- Basic Medicare Supplement (Basic Medicare Blue, Plan K and Plan L): Medicare Limits

Durable Medicare Equipment (DME) and Supplies: Coverage is furnished for DME in coordination with Medicare.

- Basic Medicare Select (Senior Gold): Medicare Limits plus three (3) pints of blood
- Extended Basic Medicare Supplement (Extended Basic Blue): Medicare limits plus blood and blood products, casts, splints, trusses, braces, crutches, artificial limbs or eyes, prosthetic appliances (excluding dental), oxygen, medical equipment rental or purchase (when appropriate), radium and other radioactive materials, anesthetics and their administration, diagnostic x-rays, lab exams
- Basic Medicare Supplement (Basic Medicare Blue): Medicare Limits plus three (3) pints of blood
- Medicare Supplement Plan with 50 Percent Coverage (Plan K): Medicare limits plus three (3) pints of blood covered at 50%. Additional is covered at 100%.
- Medicare Supplement Plan with 75 Percent Coverage (Plan L): Medicare limits plus three (3) pints of blood covered at 75%. Additional is covered at 100%.

Cancer Screening: Coverage is furnished for routine screening procedures for cancer, including pap smears, mammograms, ovarian, fecal occult blood tests, sigmoidoscopies, colorectal, colonoscopies, anoscopies, prostate specific antigen tests when ordered or performed by a physician in accordance with the standard practice of medicine.

- All Plans: 100% for eligible expenses

Immunizations/Vaccines: Coverage is furnished at 100% for the cost of preventive immunizations and vaccines except if otherwise covered by Medicare Part D.

- All Plans: 100% for eligible expenses

Treatment of Diagnosed Lyme Disease: Coverage is provided for the treatment of diagnosed Lyme disease.

- All Plans: 80% for eligible expenses

Management and Treatment of Diabetes: Coverage is furnished for physician prescribed equipment and supplies used for the management and treatment of gestational, Type I or Type II diabetes, in coordination with Medicare and not otherwise covered by the Medicare Part D program. Coverage also includes urine testing tabs, diabetes outpatient self-management training and education including medical nutrition therapy that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage does not include nonprescription supplies such as alcohol swabs and cotton balls.

- All Plans: 80% for urine test tabs, diabetes self-management training and nutrition therapy

Mental Health: Coverage is furnished for mental health care in coordination with Medicare guidelines.

- All Plans: Medicare Limits for outpatient benefits. Additional benefits for eligible inpatient mental health services

Chiropractic Care: Coverage is furnished for chiropractic care in coordination with Medicare

- All Plans: Medicare Limits

Benefits Beyond Medicare Coverage

Residential Treatment Program: Coverage is furnished for services and supplies received in a residential program for the treatment of alcoholism, chemical dependency or drug addiction.

- All Plans: 80% for eligible expenses

Nonresidential Treatment Program: Coverage is furnished for services and supplies received in a nonresidential program for the treatment of alcoholism, chemical dependency or drug addiction.

- All Plans: 80% for eligible expenses

Temporomandibular Joint Disorder (TMJ) and Craniomandibular Joint Disorder (CMJ): Coverage is furnished for services and supplies received from a participating provider for the surgical or nonsurgical treatment of TMJ and CMJ in coordination with Medicare. Specific rules apply. Please read your contract language carefully to determine specific benefits and coverage.

- All Plans: 80% for eligible expenses

Wigs: Coverage is furnished for scalp hair prostheses (wigs). Hair loss must be due to alopecia areata only. The maximum benefit is one prosthesis per benefit year.

- All Plans: 80% for eligible expenses

Ventilator-Dependent Communication Services: Coverage is furnished for services provided by a private duty nurse for a ventilator-dependent person in a hospital licensed by the State of Minnesota. There is a 120-hour lifetime maximum benefit. The private duty nurse shall perform only the services of interpreter or communicator for the patient during the transition period to assure adequate training of the hospital staff in communicating with the ventilator-dependent person.

- All Plans: 80% for eligible expenses

Reconstructive Surgery: Coverage is furnished for reconstructive surgery incidental to or following surgery resulting from injury, sickness or diseases of the involved body part including breast reconstruction and prosthesis following a mastectomy. Reconstruction surgery due to accident is not covered on this plan.

- All Plans: 80% for eligible expenses

Foreign Travel: Coverage is furnished for medically necessary emergency services received when traveling outside the United States.

- All plans except, Standard Medicare Supplemental Plan K and Standard Medicare Supplement Plan L: 80% for eligible expenses

Preventive/Routine Exams: Coverage is furnished for routine or preventive eye examinations, hearing examinations, and other routine screenings when performed by a participating provider.

- Basic Medicare Select (Senior Gold): Optional coverage up to \$120 benefit per calendar year when performed by a participating provider if in Minnesota
- Extended Basic Medicare Supplement (Extended Basic Blue): \$120 limit per calendar year
- Basic Medicare Supplement (Basic Medicare Blue): Optional coverage \$120 limit per calendar year

Member Out-of-Pocket Limitations:

- Extended Basic Medicare Supplement (Extended Basic Blue): This product covers 100% of all eligible charges after a member total annual out-of-pocket maximum of \$1,000 has been reached for eligible services
- Medicare Supplement Plan with 50 Percent Coverage (Plan K): This product covers 100% of eligible charges after a member total annual out-of-pocket maximum of \$4,940 in 2014 has been reached for eligible services
- Medicare Supplement Plan with 75 Percent Coverage (Plan L): This product covers 100% of eligible charges after a member total annual out-of-pocket maximum of \$2,470 in 2014 has been reached for eligible services

III. EXCLUSIONS

The following is a summary of items that are excluded from coverage on all contracts. Please read your contract language carefully to determine specific benefits and coverage.

1. Charges for services not allowed by Medicare, except as stated in Section II of this disclosure
2. Charges for services or supplies ordinarily covered by a liability policy and charges for any illness covered by Workers' Compensation, a no-fault automobile policy or similar law, to the extent that the illness or accident is covered by that policy
3. Charges for any illness or injury covered by an act of war or occurring while serving military duty
4. Charges for cosmetic surgery, except to repair a defect caused by an accident or medical condition that is not covered by another insurance policy
5. Charges for reconstructive surgery, except that which is incidental to or following surgery resulting from injury, sickness or diseases of the involved body part
6. Charges for any treatment, service or supply that is not medically necessary according to the standard practice of medicine or for which you receive a nonmedical benefit
7. Any diagnostic admission if such diagnostic tests can be performed on an outpatient basis as determined by our medical staff or independent medical physician review panel
8. Charges for therapeutic acupuncture
9. Charges for surgery or treatment that is investigative
10. Charges for marriage or family counseling, or other counseling not approved by Medicare
11. Charges for recreational or educational therapy or forms of nonmedical self-help training or diagnostic testing
12. Charges for the services of clergy
13. Charges for organ transplants, except for a bone marrow transplant related to breast cancer, or transplants covered by Medicare
14. Charges for treatment while confined in a state, federal or Veterans Administration hospital for which charges are not imposed
15. Charges for services or supplies outside the scope of the provider's licensure
16. Charges for routine care unless you have purchased such coverage, including screenings, research studies and other services or supplies not due to an illness
17. Charges for eyeglasses not approved by Medicare, or hearing aids, or examinations for eyeglasses or hearing aids not specified in the contract
18. Charges for surgery or other medical treatment of refractive errors (including but not limited to radial keratotomy)
19. Charges for most types of custodial care
20. Charges for dental care
21. Charges for most types of private duty nursing except as specified under the Ventilator-Dependent Communication Services on page 9
22. Charges that a provider gives one's self or renders to family members
23. Any charge for drugs and supplies for high dose chemotherapy and the related course of cancer treatment; drugs and supplies when the initial treatment plan includes or anticipates autologous bone marrow rescue, stem cell rescue, or biotechnological drug therapy.

24. Charges for over-the-counter drugs, vitamin therapy or treatment and appetite suppressants
25. Charges for services, treatment, equipment, drugs, and devices that do not meet generally accepted standards of medical practice
26. Charges for outpatient prescription drugs
27. For Select Contract Only - Charges for inpatient and preventative care services received in the State of Minnesota from a nonparticipating provider.

IV. OTHER INFORMATION

A. Guarantee Issue

Notice of Medicare Supplement Insurance Portability for Persons Ending or Losing Other Health Coverage. Should you change, lose or cancel your Medicare Supplement and Select coverage with us, you may qualify for the following provision:

Changes in federal and state law contain rights and obligations about issuing Medicare Supplement contracts. The guarantee issue provisions discussed here are in addition to the six (6)-month open-enrollment window that Medicare enrollees currently have when they enroll in Medicare Part B.

Our Obligation

Blue Cross must guarantee issue certain basic Medicare Supplement and Select contracts to eligible individuals in specific circumstances and may not deny them coverage. We cannot discriminate in the pricing of such a contract because of health status, claims experience, receipt of health care, medical condition or age. We cannot impose a preexisting condition exclusion.

Your Rights

If a Medicare beneficiary loses health coverage under the circumstances listed below, the beneficiary is guaranteed the right to purchase certain Medicare Supplement or Select contracts.

1. In Minnesota, an eligible individual is a person who is eligible for Medicare and who:
 - a) was enrolled in an employer provided retiree benefit plan that provided health benefits that supplement Medicare and the plan terminates or ceases to provide all supplemental benefits; or was enrolled in Medicare Part B and voluntarily disenrolls due to coverage under an employer plan and is subsequently applying within six (6) months of re-enrolling in Medicare Part B due to the termination of employer-sponsored coverage;
 - b) was enrolled in a Medicare Advantage, Medicare Select, Medicare Cost, or Health Care Prepayment Plan, and the enrollment ends because:
 - i) the plan's certification under Medicare has been terminated or the plan discontinues providing benefits in the area in which the person resides;
 - ii) the individual cannot continue with the plan because the individual changes residence; or
 - iii) the individual demonstrates that the plan violated a material provision of the contract for coverage or that the organization materially misrepresented the plan's provisions in marketing;
 - c) was enrolled in a Medicare supplement contract and the enrollment ends because:
 - i) the insurer becomes insolvent or other involuntary termination of coverage occurs;
 - ii) the insurer substantially violated a material provision of the contract or materially misrepresented the policy's provisions in marketing the contract to the individual.

Eligible individuals described in numbers a) through c) (above) are entitled to a Basic Medicare Supplement or a Basic Medicare Select contract from any Minnesota issuer.

d) was enrolled under a Medicare Supplement contract and terminates coverage to enroll for the first time in a Medicare Advantage, Medicare Cost, Health Care Prepayment Plan, or Medicare Select plan, and the individual then disenrolls from that plan within the first 12 months.

Eligible individuals are entitled to the same Medicare Supplement contract in which the individual was most recently enrolled, if available, from the same issuer. If the contract is not available, the person is entitled to a Basic Medicare Supplement or Select contract offered by any issuer.

e) After first enrolling in Medicare Part B, enrolls in a Medicare Advantage plan and then disenrolls from that plan within 12 months. Eligible individuals are entitled to any Medicare Supplement or Select contract offered by any issuer.

You must apply for Blue Cross Medicare Supplement or Select coverage within 63 calendar days of the date your coverage terminates (listed above) in order for us to determine if guarantee issue of coverage applies to you. If you apply after this 63-day period, you may be required to complete a health history application. If your Medicare Advantage plan is terminating, you have 63 days from the date of your plan's official Notice of Termination, as well as 63 calendar days after the plan's actual termination, to apply for Blue Cross coverage under guarantee issue. If your employer group coverage is being terminated you have 63 days from the date of official notice or from the date that you are notified of a denied claim. Applications outside of those periods may require a completed health history application, unless you are otherwise eligible for guarantee issue of coverage.

B. Right To Return Contract

If you are not satisfied with your coverage for any reason you may return your contract to:

Blue Cross Blue Shield of Minnesota
P.O. Box 64560
St. Paul, MN 55164-0560

We will then return all payments (including any fees or charges if applicable) made for this contract within 10 business days after we receive the returned contract and cancellation notice. The contract will then be considered void from the beginning. If before the end of the 30 day period, you have incurred expenses and request coverage for claims in excess of the amount of your monthly premium for that period, no refund will be made for that period.

C. Replacing a Policy, Certificate or Contract

If you are purchasing or canceling a supplement from Blue Cross, DO NOT cancel your old coverage until your new coverage is approved and you are certain that you want to keep it. This will prevent a lapse in coverage.

D. Notice of Noncoverage

Your Blue Cross Supplement or Select coverage may not fully cover all your medical costs. Please read your contract language carefully to determine specific benefits and coverage. Remember that Medicare determines if the services available on your Supplement or Select contract are eligible for coverage.

E. Relationship to Medicare

Neither Blue Cross nor its agents are associated with Medicare.

F. Completing Your Application for Coverage

Should you have any questions as you fill out your application for coverage, please call your Blue Cross agent or Medicare consultant for assistance. We are happy to help.

As you fill out the application for new coverage or make optional benefit changes to your existing coverage, please be sure to answer all application questions about

your medical and health history truthfully and completely. Blue Cross may cancel your coverage or refuse to pay your claims, or adjust your rate, if you omit or falsify important medical information.

Carefully review the application before you sign it.

G. Grievance Procedures (Basic Medicare Select)

In compliance with state statutes governing Medicare Select Plans, Blue Cross has established the following procedures for resolution of complaints concerning either the provision of health care or Blue Cross' administration of the terms of this contract:

1. If you orally notify Blue Cross that you wish to register a complaint, Blue Cross shall promptly provide a complaint form that includes:
 - a) the telephone number for service or other departments, or persons equipped to advise complaints;
 - b) the address to which the form must be sent;
 - c) a description of Blue Cross' internal complaint system and time limits applicable to that system; and
 - d) the telephone number to call to inform the Commissioner of Commerce.
2. Blue Cross shall provide for informal discussions, consultations, conferences, or correspondence between you and a person with the authority to resolve or recommend the resolution of the complaint. Within 30 calendar days after receiving the written complaint, Blue Cross must notify you in writing of its decision and the reasons for it. If the decision is partially or wholly adverse to you, the notification must advise you of the right to appeal according to item 3, including your option for a written reconsideration or a hearing, the right to arbitrate according to item 4, and the right to notify the Commissioner of Commerce. If Blue Cross cannot make a decision within 30 calendar days due to circumstances outside the control of Blue Cross, Blue Cross may take up to an additional 14 calendar days to notify you, provided Blue Cross informs you in advance of the extension of the reasons for the delay.
3. If you notify Blue Cross in writing of your desire to appeal Blue Cross' initial decision, Blue Cross shall provide you the option of a hearing or a written reconsideration.
 - a) If you choose a hearing, a person or persons with authority to resolve or recommend the resolution of the complaint shall preside, but the person or persons presiding must not be solely the same person or persons who made the decision under item 2.
 - b) If you choose a written reconsideration, those with authority to resolve the complaint shall investigate the complaint, but the person or persons investigating must not be solely the same person or persons who made the decision under item 2.
 - c) Hearings and written reconsiderations shall include the receipt of testimony, correspondence, explanations, or other information from you, staff persons, administrators, providers, or other persons, as is deemed necessary by the person or persons investigating the complaint in the case of a reconsideration or presiding person or persons in the case of a hearing for a fair appraisal and resolution of the complaint.
 - d) In the case of a written reconsideration, a written notice of all key findings shall be given to you within 30 days of Blue Cross' receipt or your written notice of appeal.

- e) In the case of a hearing, concise written notice of all key findings shall be given to you within 45 days after Blue Cross' receipt of your written notice of appeal.
- 4. You may request, or Blue Cross shall provide the opportunity for binding arbitration of any complaint which is unresolved by the mechanisms set forth in the appeal process noted in item 2. Arbitration must be conducted according to the American Arbitration Association and Minnesota Health Maintenance Organization Arbitration Rules.
- 5. If the subject of the complaint relates to a malpractice claim, the complaint shall not be subject to arbitration.
- 6. If a complaint involves a dispute about an immediately and urgently needed service that Blue Cross claims is experimental or investigative, not medically necessary, or otherwise not generally accepted by the medical profession, the procedures in items 1 to 4 do not apply. Blue Cross must use an expedited dispute resolution process appropriate to the particular situation.
 - a) By the end of the next business day after the complaint is registered, Blue Cross shall notify the Commissioner of Commerce of the nature of the complaint, the decision of Blue Cross, if any, and a description of the review process used or being used.
 - b) If a decision is not made by the end of the next business day following the registration of the complaint, Blue Cross shall notify the Commissioner of Commerce of its decision by the end of the next business day following its decision.
 - c) For purposes of this item, complaints need not be in writing.

You may contact the Commissioner of Commerce at any time at:

Minnesota Department of Commerce
85 7th Place East, Suite 500
St. Paul, MN 55101
Telephone: 651-539-1600
Fax: 651-539-1547

H. Suspension Based on Entitlement to Medical Assistance

If suspension occurs and if the policyholder or certificate holder loses entitlement to this medical assistance, the policy or certificate shall be automatically reinstated, effective as of the date of termination of this entitlement, if the policyholder or certificate holder provides notice of loss of the entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

V. RATE INFORMATION

2015 Rates

Basic Medicare Select (Senior Gold):			Basic Medicare Supplement (Basic Medicare Blue):			Extended Basic Supplement (Extended Basic Blue):		
Monthly Rates	Tobacco-Free	Standard Rate	Monthly Rates	Tobacco-Free	Standard Rate	Monthly Rates	Tobacco-Free	Standard Rate
Your cost:	\$170.35	\$204.35	Your cost:	\$155.80	\$181.45	Your cost:	\$512.00	\$644.00
Part A deductible	\$28.00	\$28.00	Part A deductible	\$28.00	\$28.00			
Part B deductible	\$12.65	\$12.65	Part B deductible	\$12.65	\$12.65			
Coverage of 100% of usual and customary charges	\$1.00	\$1.00	Coverage of 100% of usual and customary charges	\$1.00	\$1.00			
Optional benefits: Preventive care	\$4.00	\$4.00	Optional benefits: Preventive care	\$4.00	\$4.00			
Total including all optional benefits	\$216.00	\$250.00	Total including all optional benefits	\$201.45	\$227.10			

Medicare Supplement (Plan K):			Medicare Supplement (Plan L):		
Monthly Rates	Tobacco-Free	Standard Rate	Monthly Rates	Tobacco-Free	Standard Rate
Your cost:	\$109.50	\$127.50	Your cost:	\$144.70	\$169.70

