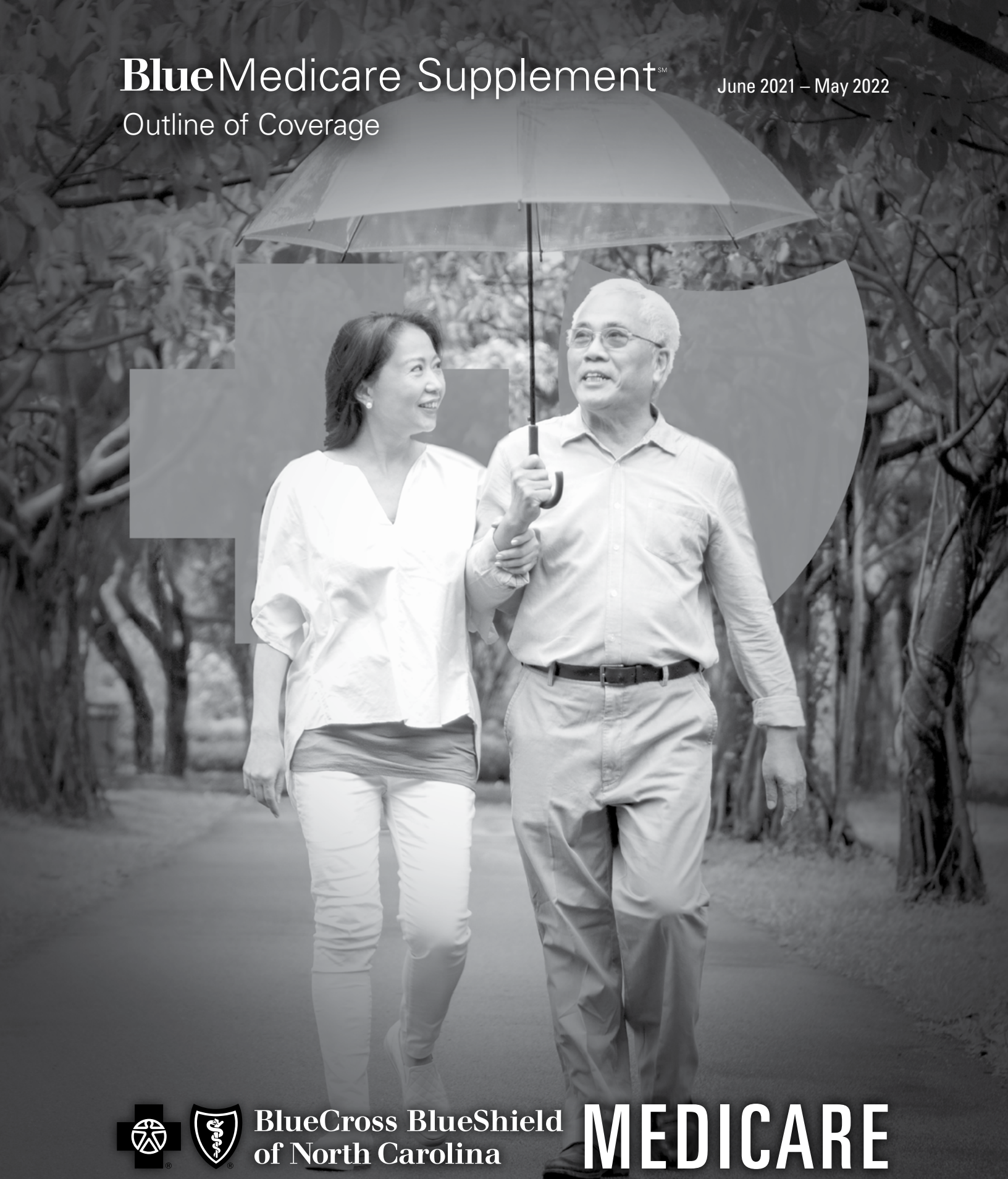
BlueMedicare Supplement℠

Outline of Coverage

June 2021 – May 2022



BlueCross BlueShield of North Carolina

MEDICARE

Visit ***Medicare.BlueCrossNC.com***

D98, 12/20

About Medicare Supplement Plans

Premium Information
Blue Cross and Blue Shield of North Carolina (Blue Cross NC) can only raise your premium if we raise the premium for all policies like yours in this state. For attained-age policies, your premium may change on June 1 each year.

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 NC, Attention: Blue Medicare Supplement Enrollment, P.O. Box 17168, Winston-Salem, NC 27116.

If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

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

Notice
This policy may not fully cover all of your medical costs. Neither Blue Cross NC 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 *Medicare & You,* which you can view and download at *Medicare.gov,* 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.

Please refer to ***Choosing a Medigap Policy: Guide to Health Insurance for People with Medicare*** located online at ***Medicare.gov*.**

Notes:
- Medicare benefits are subject to change.
- **Medicare deductibles and copayments are effective through December 31, 2021.**

Benefits	Plan A pays BMS A, 12/18	Plan G pays BMS G,12/18	High Deductible Plan G[1] pays BMS HDG, 12/18	Plan K pays BMS K, 12/18	Plan N pays BMS N, 12/18
Part A (Hospitalization)					
$1,484 inpatient hospital deductible each benefit period		✓	✓	Covers 50%[4]	✓
$371 a day copayment for days 61–90 in a hospital	✓	✓	✓	✓	✓
$742 a day copayment for days 91–150 (lifetime reserve[2])	✓	✓	✓	✓	✓
100% of Medicare-allowable expenses for additional 365 days after Medicare hospital benefits are exhausted	✓	✓	✓	✓	✓
$185.50 per day for days 21–100 in a skilled nursing facility[3]		✓	✓	Covers 50%[4]	✓
Part B (Physician and Medical Services)					
Generally, 80% of Medicare-approved amount (Part B coinsurance) after Part B deductible is met	✓	✓	✓	✓	Up to $20 per office visit Up to $50 per ER visit
100% of Medicare Part B excess charges		✓	✓		
Silver&Fit® offered	✓	✓		✓	✓
TruHearing® offered	✓	✓	✓	✓	✓

✓ Benefit included in plan.

1 Benefits for this plan will not begin until your $2,370 deductible is met.

2 After 90 days of hospitalization, Medicare benefits are paid from a one-time, lifetime reserve of 60 additional days, which are not renewable each benefit period.

3 You must have been in a hospital for at least three days and enter a Medicare-approved facility within 30 days after hospital discharge.

4 Until annual out-of-pocket limit of $6,220 is met.

Benefits

Benefit Chart of Medicare Supplement Plans Effective on or After January 1, 2021

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.

Attained-Age Plans[1]				
Plan A[2]	**Plan G[2]**	**High Deductible Plan G[3]**	**Plan K**	**Plan N**
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%	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	50% Skilled nursing facility coinsurance	Skilled nursing facility coinsurance
	Part A deductible	Part A deductible	50% Part A deductible	Part A deductible
	Part B excess (100%)	Part B excess (100%)		
	Foreign travel emergency	Foreign travel emergency		Foreign travel emergency
			Out-of-pocket limit $6,220; paid at 100% after limit reached	

Basic Benefits

- **Blood** - First 3 pints of blood each year
- **Hospice** - Part A coinsurance
- **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 and N require insured to pay a portion of Part B coinsurance or copayments

Notes:
1 When you enroll in an attained-age plan, your rates will increase as you age, due to your age. Your rates will only increase due to age when you move from one age band to the next. In addition, rate adjustments will also be due to medical inflation or overall claims experience. Rates are subject to change June 1 of each year and are guaranteed for 12 months from that date. Any change in your rate will be preceded by a 30 day notice.
2 Individuals under 65 and on Medicare are only eligible for Plan A or Plan G.
3 Plan G also has an option called a high deductible Plan G. This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,370 deductible. Benefits from high deductible Plan G will not begin until out-of-pocket expenses exceed $2,370. 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.

BMS A, 12/18; BMS G, 12/18; BMS HDG, 12/18; BMS K, 12/18; BMS N, 12/18.

Attained-Age Plans

Blue Cross NC offers Medicare supplement plans with attained-age rates.

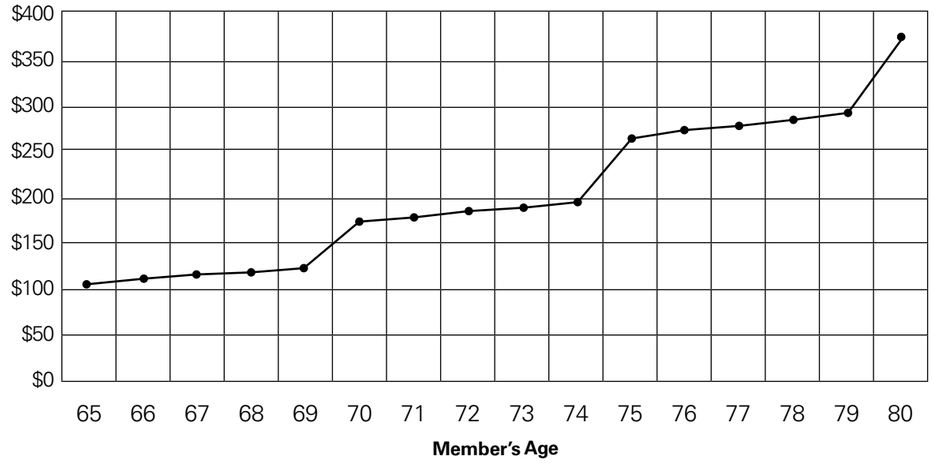
When you enroll in an attained-age plan, your rates will increase as you age, due to your age. Our rates will only increase due to age when you move from one age band to the next. In addition, rate adjustments will also be due to medical inflation or overall claims experience. Note: Rates are subject to change June 1 of each year and are guaranteed to remain the same for 12 months from that date. Any change in your rate will be preceded by a 30 day notice. Medicare policies that are attained-age rated should be compared to entry-age rated policies (also known as issue-age rated policies). Premiums for entry-age policies do not increase due to age as the insured ages.

The **federal government** has asked us to provide this outline of coverage **to help you decide** which **plan best fits your needs** and meets your budget.

Example of Individual Rate Changes on Attained-Age Plans

The chart below illustrates attained-age rate changes due to age and claims trend over a 15 year period.

15 Year Rate Change – Attained-Age



Notes:
- Source: Internal Blue Cross NC data, 2020.
- The chart illustrates Plan G's cost over a 15 year period. Attained-age plans will adjust on medical trends, however the premium will increase due to age. For illustrative purposes only.

BlueMedicare Supplement™

Monthly Premiums

Non-Tobacco User

Age	Plan A		Plan G		High Deductible Plan G		Plan K		Plan N	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
<65	$1,214.75	$1,317.50	$1,280.00	$1,388.50	N/A	N/A	N/A	N/A	N/A	N/A
65	$111.50	$120.25	$99.75	$107.50	$38.00	$41.00	$66.75	$72.00	$89.50	$96.50
66	$117.00	$126.25	$104.25	$112.25	$38.00	$41.00	$70.75	$76.25	$93.50	$100.75
67	$121.25	$130.75	$109.00	$117.50	$38.00	$41.00	$73.25	$79.00	$97.75	$105.50
68	$125.75	$135.50	$113.25	$122.00	$38.00	$41.00	$76.00	$82.00	$101.50	$109.50
69	$129.75	$140.75	$117.75	$127.00	$38.00	$41.00	$78.50	$84.75	$105.75	$114.00
70	$140.00	$151.00	$147.25	$158.75	$39.25	$42.25	$90.75	$98.00	$132.00	$142.50
71	$147.00	$158.50	$154.50	$166.75	$39.25	$42.25	$95.25	$103.00	$138.75	$149.50
72	$154.00	$166.00	$162.00	$174.75	$39.25	$42.25	$100.00	$107.75	$145.25	$156.75
73	$161.00	$173.75	$169.50	$182.75	$39.25	$42.25	$104.50	$112.75	$152.00	$164.00
74	$168.00	$181.25	$176.75	$190.75	$39.25	$42.25	$109.00	$117.75	$158.50	$171.00
75	$173.00	$186.50	$215.75	$232.75	$43.50	$47.00	$112.00	$121.00	$195.75	$212.75
76	$180.25	$194.50	$224.75	$242.50	$43.50	$47.00	$116.75	$126.00	$204.75	$222.50
77	$187.75	$202.25	$234.00	$252.50	$43.50	$47.00	$121.50	$131.25	$214.00	$232.50
78	$195.00	$210.25	$243.25	$262.25	$43.50	$47.00	$126.25	$136.25	$223.25	$242.25
79	$202.25	$218.25	$252.25	$272.25	$43.50	$47.00	$131.00	$141.50	$232.25	$252.25
80+	$202.75	$218.75	$281.75	$303.75	$43.50	$47.00	$151.00	$162.75	$261.75	$283.75

Note: **Rates are effective through May 31, 2022**.

Monthly Premiums

Tobacco User

Age	Plan A		Plan G		High Deductible Plan G		Plan K		Plan N	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
<65	$1,239.75	$1,342.50	$1,305.00	$1,413.50	N/A	N/A	N/A	N/A	N/A	N/A
65	$136.50	$145.25	$124.75	$132.50	$50.50	$53.50	$91.75	$97.00	$114.50	$121.50
66	$142.00	$151.25	$129.25	$137.25	$50.50	$53.50	$95.75	$101.25	$118.50	$125.75
67	$146.25	$155.75	$134.00	$142.50	$50.50	$53.50	$98.25	$104.00	$122.75	$130.50
68	$150.75	$160.50	$138.25	$147.00	$50.50	$53.50	$101.00	$107.00	$126.50	$134.50
69	$154.75	$165.75	$142.75	$152.00	$50.50	$53.50	$103.50	$109.75	$130.75	$139.00
70	$165.00	$176.00	$172.25	$183.75	$51.75	$54.75	$115.75	$123.00	$157.00	$167.50
71	$172.00	$183.50	$179.50	$191.75	$51.75	$54.75	$120.25	$128.00	$163.75	$174.50
72	$179.00	$191.00	$187.00	$199.75	$51.75	$54.75	$125.00	$132.75	$170.25	$181.75
73	$186.00	$198.75	$194.50	$207.75	$51.75	$54.75	$129.50	$137.75	$177.00	$189.00
74	$193.00	$206.25	$201.75	$215.75	$51.75	$54.75	$134.00	$142.75	$183.50	$196.00
75	$198.00	$211.50	$240.75	$257.75	$56.00	$59.50	$137.00	$146.00	$220.75	$237.75
76	$205.25	$219.50	$249.75	$267.50	$56.00	$59.50	$141.75	$151.00	$229.75	$247.50
77	$212.75	$227.25	$259.00	$277.50	$56.00	$59.50	$146.50	$156.25	$239.00	$257.50
78	$220.00	$235.25	$268.25	$287.25	$56.00	$59.50	$151.25	$161.25	$248.25	$267.25
79	$227.25	$243.25	$277.25	$297.25	$56.00	$59.50	$156.00	$166.50	$257.25	$277.25
80+	$227.75	$243.75	$306.75	$328.75	$56.00	$59.50	$176.00	$187.75	$286.75	$308.75

Notes:
- **Rates are effective through May 31, 2022**.
- Tobacco user rates do not apply during Guaranteed Issue period.

BlueMedicare Supplement™

Plan A

Medicare (Part A) – **Hospital Services** (per benefit period)

		Medicare pays	Plan pays	You pay
Hospitalization:[1] Semi-private room and board, general nursing and miscellaneous services and supplies.	First 60 days:	All but $1,484	$0	$1,484 (Part A deductible)
	61st through 90th day:	All but $371 a day	$371 a day	$0
	91st day and after: While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
	Once lifetime reserve days are used — additional 365 days:	$0	100% of Medicare-eligible expenses	$0[2]
	Beyond the additional 365 days:	$0	$0	All costs
Skilled nursing facility care:[1] 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 through 100th day:	All but $185.50 a day	$0	Up to $185.50 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

Footnotes:
1 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.
2 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)

			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 $203 of Medicare-approved amounts:[1]		$0	$0	$203 (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 $203 of Medicare-approved amounts:[1]		$0	$0	$203 (Part B deductible)
	Remainder of Medicare-approved amounts:		80%	20%	$0
Clinical laboratory services:	Tests for diagnostic services:		100%	$0	$0

Parts A and B

			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 $203 of Medicare-approved amounts:[1]	$0	$0	$203 (Part B deductible)
		Remainder of Medicare-approved amounts:	80%	20%	$0

Footnote:
1 Once you have been billed $203 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

BlueMedicare Supplement™

Plan G

Medicare (Part A) — **Hospital Services** (per benefit period)

		Medicare pays	Plan pays	You pay
Hospitalization:[1] Semi-private room and board, general nursing and miscellaneous services and supplies.	First 60 days:	All but $1,484	$1,484 (Part A deductible)	$0
	61st through 90th day:	All but $371 a day	$371 a day	$0
	91st day and after: While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
	Once lifetime reserve days are used — additional 365 days:	$0	100% of Medicare-eligible expenses	$0[2]
	Beyond the additional 365 days:	$0	$0	All costs
Skilled nursing facility care:[1] 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 through 100th day:	All but $185.50 a day	Up to $185.50 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

Footnotes:
1 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.
2 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 G

Medicare (Part B) — **Medical Services** (per calendar year)

			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 $203 of Medicare-approved amounts:[1]		$0	$0	$203 (Unless Part B deductible has been met)
	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 $203 of Medicare-approved amounts:[1]		$0	$0	$203 (Unless Part B deductible has been met)
	Remainder of Medicare-approved amounts:		80%	20%	$0
Clinical laboratory services:	Tests for diagnostic services:		100%	$0	$0

Parts A and B

Home health care Medicare-approved services:	Medically necessary skilled care services and medical supplies:		100%	$0	$0
	Durable medical equipment:	First $203 of Medicare-approved amounts:[1]	$0	$0	$203 (Unless Part B deductible has been met)
		Remainder of Medicare-approved amounts:	80%	20%	$0

Other Benefits Not Covered By Medicare

Foreign travel – not covered by Medicare: Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.	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

Footnote:
1 Once you have been billed $203 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

BlueMedicare Supplement™

High Deductible Plan G

Medicare (Part A) — **Hospital Services** (per benefit period)

		Medicare pays	After you pay $2,370 deductible[1] plan pays	In addition to $2,370 deductible[1] you pay
Hospitalization:[2] Semi-private room and board, general nursing and miscellaneous services and supplies.	First 60 days:	All but $1,484	$1,484 (Part A deductible)	$0
	61st through 90th day:	All but $371 a day	$371 a day	$0
	91st day and after: While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
	Once lifetime reserve days are used — additional 365 days:	$0	100% of Medicare-eligible expenses	$0[3]
	Beyond the additional 365 days:	$0	$0	All costs
Skilled nursing facility care:[2] 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 through 100th day:	All but $185.50 a day	Up to $185.50 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

Footnotes:

1 This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,370 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,370. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

2 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.

3 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.

BlueMedicare Supplement™

High Deductible Plan G

Medicare (Part B) — **Medical Services** (per calendar year)

			Medicare pays	After you pay $2,370 deductible[1] plan pays	In addition to $2,370 deductible[1] 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 $203 of Medicare-approved amounts:[2]		$0	$0	$203 (Unless Part B deductible has been met)
	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 $203 of Medicare-approved amounts:[2]		$0	$0	$203 (Unless Part B deductible has been met)
	Remainder of Medicare-approved amounts:		80%	20%	$0
Clinical laboratory services:	Tests for diagnostic services:		100%	$0	$0

Parts A and B

Home health care Medicare-approved services:	Medically necessary skilled care services and medical supplies:		100%	$0	$0
	Durable medical equipment:	First $203 of Medicare-approved amounts:[2]	$0	$0	$203 (Unless Part B deductible has been met)
		Remainder of Medicare-approved amounts:	80%	20%	$0

Other Benefits Not Covered By Medicare

Foreign travel – not covered by Medicare: Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.	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

Footnotes:

1 This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,370 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,370. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

2 Once you have been billed $203 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan K

Medicare (Part A) — **Hospital Services** (per benefit period)

		Medicare pays	Plan pays	You pay[1]
Hospitalization:[2] Semi-private room and board, general nursing and miscellaneous services and supplies.	First 60 days:	All but $1,484	$742 (50% of Part A deductible)	$742 (50% of Part A deductible)[3]
	61st through 90th day:	All but $371 a day	$371 a day	$0
	91st day and after: While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
	Once lifetime reserve days are used — additional 365 days:	$0	100% of Medicare-eligible expenses	$0[4]
	Beyond the additional 365 days:	$0	$0	All costs
Skilled nursing facility care:[2] 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 through 100th day:	All but $185.50 a day	Up to $92.75 a day (50% of Part A coinsurance)	Up to $92.75 a day[3] (50% of Part A coinsurance)
	101st day and after:	$0	$0	All costs
Blood:	First 3 pints:	$0	50%	50%[3]
	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	50% of copayment/ coinsurance	50% of Medicare copayment/ coinsurance[3]

Footnotes:
1 You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket limit of $6,220 each calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "excess charges"), and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.
2 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.
3 The amount you pay counts towards your annual out-of-pocket limit. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year.
4 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 K

Medicare (Part B) — **Medical Services** (per calendar year)

		Medicare pays	Plan pays	You pay[1]
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 $203 of Medicare-approved amounts:[2]	$0	$0	$203 (Part B deductible)[2,3]
	Preventive benefits for Medicare covered services:	Generally 80% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
	Remainder of Medicare-approved amounts:	Generally 80%	Generally 10%	Generally 10%[3]
Part B excess charges:	Above Medicare-approved amounts:	$0	$0	All costs and they do not count toward out-of-pocket limit of $6,220[5]
Blood:	First 3 pints:	$0	50%	50%[3]
	Next $203 of Medicare-approved amounts:[2]	$0	$0	$203 (Part B deductible)[2,3]
	Remainder of Medicare-approved amounts:	Generally 80%	Generally 10%	Generally 10%[3]
Clinical laboratory services:	Tests for diagnostic services:	100%	$0	$0

Parts A and B

Home health care Medicare-approved services:	Medically necessary skilled care services and medical supplies:		100%	$0	$0
	Durable medical equipment:	First $203 of Medicare-approved amounts:[4]	$0	$0	$203 (Part B deductible)[3]
		Remainder of Medicare-approved amounts:	80%	10%	10%[3]

Footnotes:
1 You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket limit of $6,220 each calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "excess charges"), and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.
2 Once you have been billed $203 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.
3 The amount you pay counts towards your annual out-of-pocket limit. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year.
4 Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*
5 This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $6,220 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Plan N

Medicare (Part A) — **Hospital Services** (per benefit period)

		Medicare pays	Plan pays	You pay
Hospitalization:[1] Semi-private room and board, general nursing and miscellaneous services and supplies.	First 60 days:	All but $1,484	$1,484 (Part A deductible)	$0
	61st through 90th day:	All but $371 a day	$371 a day	$0
	91st day and after: While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
	Once lifetime reserve days are used — additional 365 days:	$0	100% of Medicare-eligible expenses	$0[2]
	Beyond the additional 365 days:	$0	$0	All costs
Skilled nursing facility care:[1] 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 through 100th day:	All but $185.50 a day	Up to $185.50 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

Footnotes:
1 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.
2 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)

			Medicare pays	Plan pays	You pay
Medical expenses – in or out of the hospital and out-patient 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 $203 of Medicare-approved amounts:[1]		$0	$0	$203 (Part B deductible)
	Remainder of Medicare-approved amounts:		Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B excess charges:	Above Medicare-approved amounts:		$0	$0	All costs
Blood:	First 3 pints:		$0	All costs	$0
	Next $203 of Medicare-approved amounts:[1]		$0	$0	$203 (Part B deductible)
	Remainder of Medicare-approved amounts:		80%	20%	$0
Clinical laboratory services:	Tests for diagnostic services:		100%	$0	$0

Parts A and B

Home health care Medicare-approved services:	Medically necessary skilled care services and medical supplies:		100%	$0	$0
	Durable medical equipment:	First $203 of Medicare-approved amounts:[1]	$0	$0	$203 (Part B deductible)
		Remainder of Medicare-approved amounts:	80%	20%	$0

Other Benefits Not Covered By Medicare

Foreign travel – not covered by Medicare: Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.	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

Footnote:
1 Once you have been billed $203 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Limitations and Exclusions

Blue Cross NC does not provide benefits for services, supplies or charges that are:

- Not a Medicare-eligible expense under the Medicare program, unless otherwise noted;
- For treatment of a pre-existing condition before a required waiting period ends; or
- Payable under Medicare.

Please note regarding waiting periods for pre-existing conditions:

Pre-existing conditions are conditions for which medical advice was given or treatment was recommended by or received from a doctor within six months of the effective date of coverage. Coverage for such conditions may be subject to a six month waiting period after the effective date of coverage.

The six month waiting period will be reduced by the amount of time you have been enrolled under other health insurance coverage so long as the coverage terminated no more than 63 days prior to your date of application. The six month waiting period will not apply and your policy is guaranteed issue regardless of health status if you fit into one of the following categories and you applied for this policy within 63 days of terminating your old coverage (if applicable):

- If you have six months of prior health coverage;
- If, after becoming eligible for Medicare Part A at age 65, you first choose to enroll in a Medicare Advantage plan and disenroll within 12 months you may choose any Medicare supplement plan in your state;
- If, within 12 months of enrolling in your first Medicare Advantage plan, you may switch back to the same policy if the same insurance company still sells it. If your same plan isn't available, you may switch to Medicare Supplement Plan A, B, D, G, K or L that is sold in your state. (Note: If you first enroll in a Medicare Advantage plan at 65 and disenroll within 12 months, you may choose any Medicare Supplement plan.)

Additionally, waiting periods will not apply (and our policy is guaranteed issue) if:

- Your employer's Medicare Supplement plan ended;
- You disenroll from a Medicare Advantage plan or other similar state or federal Medicare program because: your plan lost its federal certification; you moved outside the plan's service area; or you terminated the coverage because your previous issuer materially misrepresented the provisions of the plan when marketing it to you;
- Your previous Medicare Supplement plan's issuer went bankrupt; or
- Your previous Medicare Supplement plan's issuer materially misrepresented or substantially violated provisions of your coverage.

Your policy is guaranteed renewable

This policy is guaranteed renewable and may not be canceled or non-renewed for any reason other than your failure to pay premiums or misstatements in or omissions of information from your application. Any change in your rate will be preceded by a 30 day notice and is guaranteed for 12 months.

Caution: Policy benefits are limited to those approved by Medicare for payment.

The Silver&Fit program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). The program is not part of a member's policy or benefits and is not available on our Plan G-HD All programs and services are not available in all areas. Please make sure to talk to a doctor before starting or changing an exercise routine. Silver&Fit, Fit at Home, and the Silver&Fit logo are trademarks of ASH. Other names or logos may be trademarks of their respective owners. Home kits are subject to change. Not all YMCAs participate in the network. ASH does not offer Blue Cross NC products or services. Not connected with or endorsed by the US government or the federal Medicare program.

TruHearing is a registered trademark of TruHearing, Inc. TruHearing is an independent company and does not offer Blue Cross NC products or services. This program may be changed or discontinued at any time.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service people with disabilities as well as free language services for people whose primary language is not English. Please contact 1-800-478-0583 (TTY: 711) for assistance.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a las personas con discapacidades, así como servicios lingüísticos gratuitos para las personas cuyo idioma principal no es el inglés. Llame al 1-800-478-0583 (TTY: 711) para obtener ayuda.

Neither Blue Cross and Blue Shield of North Carolina nor its agents are endorsed by or affiliated with the United States government or the federal Medicare program.

BlueMedicare Supplement℠

Contact **Blue Cross NC**

Phone: **1-800-478-0583** (TTY: 711)

Hours: 7 days a week, 8 a.m. – 8 p.m.

Online: ***Medicare.BlueCrossNC.com***

Centers: ***BlueCrossNC.com/Centers***

Or contact your Blue Cross NC **Authorized Agent.**