
Outline of Medicare Supplement Coverage

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.



Blue Cross and Blue Shield of North Carolina

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

Benefit Plans A, B, C, D, E, F, H, I and J

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some Plans may not be available in North Carolina.

Basic Benefits: Included in A-J Plans.

Hospitalization: Part A Coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical expenses: Part B Coinsurance (*generally 20% of Medicare-approved expenses*) or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

| A | B | C | D | E | F | F* | G | H | I | J | J* |
|----------------|-------------------|--------------------------------------|--------------------------------------|---|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|---|--------------------------------------|
| Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits | Basic Benefits |
| | | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance |
| | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible |
| | | Part B Deductible | | | Part B Deductible | | | | | Part B Deductible | |
| | | | | | Part B Excess 100% | | Part B Excess 80% | | Part B Excess 100% | Part B Excess 100% | Part B Excess 100% |
| | | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency |
| | | | At-Home Recovery | | | | At-Home Recovery | | At-Home Recovery | At-Home Recovery | |
| | | | | Preventive Care NOT covered by Medicare | | | | | | Preventive Care NOT covered by Medicare | |

| AGE | MONTHLY PREMIUMS: | | | | | | | | | | |
|----------|-------------------|-----------|-----------|----------|----------|----------|--|----------|----------|----------|-----------|
| Under 65 | \$243.50† | \$280.00‡ | \$342.25† | | | | | | | | \$397.50† |
| 65 | \$107.50 | \$131.00 | \$167.25 | \$137.25 | \$138.50 | \$136.00 | | \$153.50 | \$154.50 | \$185.50 | |
| 66-69 | \$111.00 | \$136.50 | \$181.25 | \$151.25 | \$152.50 | \$169.50 | | \$169.00 | \$170.00 | \$196.75 | |
| 70-74 | \$112.00 | \$142.25 | \$199.00 | \$163.25 | \$164.50 | \$195.00 | | \$187.00 | \$188.50 | \$209.25 | |
| 75+ | \$112.50 | \$150.25 | \$236.75 | \$201.75 | \$202.50 | \$233.00 | | \$220.75 | \$222.50 | \$248.50 | |

Rates are effective until April 1, 2009

(Shaded areas indicate Blue Cross and Blue Shield of North Carolina plans for which you may be eligible.)

* Plans F and J also have an option called a high-deductible Plan F and a high-deductible Plan J. These high-deductible plans pay the same benefits as Plan F and J after one has paid a calendar year \$1,900 deductible. Benefits from high-deductible Plans F and J will not begin until out-of-pocket expenses exceed \$1,900. 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.

† Medicare supplement rates for individuals who are on Medicare due to disability.

‡ Plan B rate is only available to current Blue Cross and Blue Shield of North Carolina Subscribers who qualify for Medicare due to disability.

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

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

| J | K** | L** |
|---|---|---|
| Basic Benefits | 100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services | 100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services |
| Skilled Nursing Coinsurance | 50% Skilled Nursing Facility Coinsurance | 75% Skilled Nursing Facility Coinsurance |
| Part A Deductible | 50% Part A Deductible | 75% Part A Deductible |
| Part B Deductible | | |
| Part B Excess (100%) | | |
| Foreign Travel Emergency | | |
| At-Home Recovery | | |
| Preventive Care NOT Covered by Medicare | | |
| | \$4,440 Out of Pocket Annual Limit*** | \$2,220 Out of Pocket Annual Limit*** |

** Plans K and L provide for different cost-sharing for items and services than Plans A through J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation. See Outlines of Coverage for details and exceptions.

PREMIUM INFORMATION

Blue Cross and Blue Shield of North Carolina can only raise your premium if we raise the premium for all policies like yours in the state.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Blue Cross and Blue Shield of North Carolina, Attention: Blue Medicare SupplementSM Enrollment, PO 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 and Blue Shield of North Carolina 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* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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

PLAN A

Medicare (Part A) — Hospital Services — Per Benefit Period

| 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 \$1,024/ benefit period* | \$0 | \$1,024 |
| 61st through 90th day | All but \$256 a day | \$256/day | \$0 |
| 91st day and after: While using 60 lifetime reserve days | All but \$512 a day | \$512/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 through 100th day | All but \$128 a day | \$0 | Up to \$128 a day |
| 101st day and after | \$0 | \$0 | All costs |
| BLOOD | | | |
| First three pints | \$0 | 3 pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | \$0 | Balance |

* 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.

** **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.

Note: Medicare deductibles and copayments are effective through December 31, 2008

PLAN A – *Continued*

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 \$135 of Medicare-Approved Amounts*** <i>(Part B Deductible)</i> | \$0 | \$0 | \$135 <i>(Part B Deductible)</i> |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 20%**** | \$0 |
| Part B Excess Charges <i>(Above Medicare-Approved Amounts)</i> | \$0 | \$0 | All costs |
| BLOOD | | | |
| First three pints | \$0 | All costs | \$0 |
| Next \$135 of Medicare-Approved Amounts*** | \$0 | \$0 | \$135 <i>(Part B Deductible)</i> |
| Remainder of Medicare-Approved Amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES — Tests For Diagnostic Services | 100% | \$0 | \$0 |
| MEDICARE 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 \$135 of Medicare-Approved Amounts*** | \$0 | \$0 | \$135 <i>(Part B Deductible)</i> |
| Remainder of Medicare-Approved Amounts | 80% | 20% | \$0 |

*** Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with a triple asterisk), your Part B Deductible will have been met for the calendar year.

****However, Medicare may pay 50% of the Approved Amount for mental health services; then Plan payment increases to 50% of the Approved Amount.

PLAN B

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 \$1,024/ benefit period* | \$1,024* | \$0 |
| 61st through 90th day | All but \$256 a day | \$256/day | \$0 |
| 91st day and after: While using 60 lifetime reserve days | All but \$512 a day | \$512/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 through 100th day | All but \$128 a day | \$0 | Up to \$128 a day |
| 101st day and after | \$0 | \$0 | All costs |
| BLOOD | | | |
| First three pints | \$0 | 3 pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | \$0 | Balance |

* 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.

** **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.

Note: Medicare deductibles and copayments are effective through December 31, 2008

PLAN B – *Continued*

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 \$135 of Medicare-Approved Amounts*** <i>(Part B Deductible)</i> | \$0 | \$0 | \$135 <i>(Part B Deductible)</i> |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 20%**** | \$0 |
| Part B Excess Charges <i>(Above Medicare-Approved Amounts)</i> | \$0 | \$0 | All costs |
| BLOOD | | | |
| First three pints | \$0 | All costs | \$0 |
| Next \$135 of Medicare-Approved Amounts*** | \$0 | \$0 | \$135 <i>(Part B Deductible)</i> |
| Remainder of Medicare-Approved Amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES — Tests For Diagnostic Services | 100% | \$0 | \$0 |
| MEDICARE 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 \$135 of Medicare-Approved Amounts*** | \$0 | \$0 | \$135 <i>(Part B Deductible)</i> |
| Remainder of Medicare-Approved Amounts | 80% | 20% | \$0 |

*** Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with a triple asterisk), your Part B Deductible will have been met for the calendar year.

****However, Medicare may pay 50% of the Approved Amount for mental health services; then Plan payment increases to 50% of the Approved Amount.

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 \$1,024/ benefit period* | \$1,024* | \$0 |
| 61st through 90th day | All but \$256 a day | \$256/day | \$0 |
| 91st day and after: While using 60 lifetime reserve days | All but \$512 a day | \$512/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 through 100th day | All but \$128 a day | Up to \$128 a day | \$0 |
| 101st day and after | \$0 | \$0 | All costs |
| BLOOD | | | |
| First three pints | \$0 | 3 pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | \$0 | Balance |

* 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.

** **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.

Note: Medicare deductibles and copayments are effective through December 31, 2008

PLAN C – *Continued*

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 \$135 of Medicare-Approved Amounts*** (Part B Deductible) | \$0 | \$135 (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 three pints | \$0 | All costs | \$0 |
| Next \$135 of Medicare-Approved Amounts*** | \$0 | \$135 (Part B Deductible) | \$0 |
| Remainder of Medicare-Approved Amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES — Tests For Diagnostic Services | 100% | \$0 | \$0 |
| MEDICARE 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 \$135 of Medicare-Approved Amounts*** | \$0 | \$135 (Part B Deductible) | \$0 |
| 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 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 maximum |

*** Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with a triple asterisk), your Part B Deductible will have been met for the calendar year.

****However, Medicare may pay 50% of the Approved Amount for mental health services; then Plan payment increases to 50% of the Approved Amount.

PLAN D

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 \$1,024/ benefit period* | \$1,024* | \$0 |
| 61st through 90th day | All but \$256 a day | \$256/day | \$0 |
| 91st day and after: While using 60 lifetime reserve days | All but \$512 a day | \$512/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 through 100th day | All but \$128 a day | Up to \$128 a day | \$0 |
| 101st day and after | \$0 | \$0 | All costs |
| BLOOD | | | |
| First three pints | \$0 | 3 pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | \$0 | Balance |

* 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.

** **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.

Note: Medicare deductibles and copayments are effective through December 31, 2008

PLAN D – *Continued*

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 \$135 of Medicare-Approved Amounts*** (<i>Part B Deductible</i>) | \$0 | \$0 | \$135 (Part B Deductible) |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 20%**** | \$0 |
| Part B Excess Charges (<i>Above Medicare-Approved Amounts</i>) | \$0 | \$0 | All costs |
| BLOOD | | | |
| First three pints | \$0 | All costs | \$0 |
| Next \$135 of Medicare-Approved Amounts*** | \$0 | \$0 | \$135 (Part B Deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES — Tests For Diagnostic Services | 100% | \$0 | \$0 |
| MEDICARE 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 \$135 of Medicare-Approved Amounts*** | \$0 | \$0 | \$135 (Part B Deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | \$0 |
| AT-HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE — Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan Benefit for each visit | \$0 | Actual charges up to \$40 a visit | Balance |
| Number of visits covered (<i>must be received within eight weeks of last Medicare-Approved visit</i>) | \$0 | Up to the number of Medicare-Approved visits, not to exceed 7 each week | \$0 |
| Calendar year maximum | \$0 | \$1,600 | \$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 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 maximum |

*** Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with a triple asterisk), your Part B Deductible will have been met for the calendar year.

****However, Medicare may pay 50% of the Approved Amount for mental health services; then Plan payment increases to 50% of the Approved Amount.

PLAN E

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 \$1,024/ benefit period* | \$1,024* | \$0 |
| 61st through 90th day | All but \$256 a day | \$256/day | \$0 |
| 91st day and after: While using 60 lifetime reserve days | All but \$512 a day | \$512/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 through 100th day | All but \$128 a day | Up to \$128 a day | \$0 |
| 101st day and after | \$0 | \$0 | All costs |
| BLOOD | | | |
| First three pints | \$0 | 3 pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | \$0 | Balance |

* 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.

** **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.

Note: Medicare deductibles and copayments are effective through December 31, 2008

PLAN E – *Continued*

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 \$135 of Medicare-Approved Amounts*** <i>(Part B Deductible)</i> | \$0 | \$0 | \$135 <i>(Part B Deductible)</i> |
| Remainder of Medicare-Approved Amounts | Generally 80% | Generally 20%**** | \$0 |
| Part B Excess Charges <i>(Above Medicare-Approved Amounts)</i> | \$0 | \$0 | All costs |
| BLOOD | | | |
| First three pints | \$0 | All costs | \$0 |
| Next \$135 of Medicare-Approved Amounts*** | \$0 | \$0 | \$135 <i>(Part B Deductible)</i> |
| Remainder of Medicare-Approved Amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES — Tests For Diagnostic Services | 100% | \$0 | \$0 |
| MEDICARE 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 \$135 of Medicare-Approved Amounts*** | \$0 | \$0 | \$135 <i>(Part B Deductible)</i> |
| 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 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 maximum |
| PREVENTIVE MEDICAL CARE BENEFIT — NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year | \$0 | \$120 | \$0 |
| Additional charges | \$0 | \$0 | All costs |

*** Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with a triple asterisk), your Part B Deductible will have been met for the calendar year.

**** However, Medicare may pay 50% of the Approved Amount for mental health services; then Plan payment increases to 50% of the Approved Amount.

PLAN F

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 \$1,024/ benefit period* | \$1,024* | \$0 |
| 61st through 90th day | All but \$256 a day | \$256/day | \$0 |
| 91st day and after: While using 60 lifetime reserve days | All but \$512 a day | \$512/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 through 100th day | All but \$128 a day | Up to \$128 a day | \$0 |
| 101st day and after | \$0 | \$0 | All costs |
| BLOOD | | | |
| First three pints | \$0 | 3 pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | \$0 | Balance |

* 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.

** **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.

Note: Medicare deductibles and copayments are effective through December 31, 2008

PLAN F – *Continued*

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 \$135 of Medicare-Approved Amounts*** (Part B Deductible) | \$0 | \$135 (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 three pints | \$0 | All costs | \$0 |
| Next \$135 of Medicare-Approved Amounts*** | \$0 | \$135 (Part B Deductible) | \$0 |
| Remainder of Medicare-Approved Amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES — Tests For Diagnostic Services | 100% | \$0 | \$0 |
| MEDICARE 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 \$135 of Medicare-Approved Amounts*** | \$0 | \$135 (Part B Deductible) | \$0 |
| 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 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 maximum |

*** Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with a triple asterisk), your Part B Deductible will have been met for the calendar year.

****However, Medicare may pay 50% of the Approved Amount for mental health services; then Plan payment increases to 50% of the Approved Amount.

PLAN H

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 \$1,024/ benefit period* | \$1,024* | \$0 |
| 61st through 90th day | All but \$256 a day | \$256/day | \$0 |
| 91st day and after: While using 60 lifetime reserve days | All but \$512 a day | \$512/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 through 100th day | All but \$128 a day | All but \$128 a day | \$0 |
| 101st day and after | \$0 | \$0 | All costs |
| BLOOD | | | |
| First three pints | \$0 | 3 pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | \$0 | Balance |

* 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.

** **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.

Note: Medicare deductibles and copayments are effective through December 31, 2008

PLAN H – *Continued*

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 \$135 of Medicare-Approved Amounts*** (Part B Deductible) | \$0 | \$0 | \$135 (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 three pints | \$0 | All costs | \$0 |
| Next \$135 of Medicare-Approved Amounts*** | \$0 | \$0 | \$135 (Part B Deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES — Tests For Diagnostic Services | 100% | \$0 | \$0 |
| MEDICARE 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 \$135 of Medicare-Approved Amounts*** | \$0 | \$0 | \$135 (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 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 maximum |

*** Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with a triple asterisk), your Part B Deductible will have been met for the calendar year.

****However, Medicare may pay 50% of the Approved Amount for mental health services; then Plan payment increases to 50% of the Approved Amount

PLAN I

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 \$1,024/ benefit period* | \$1,024* | \$0 |
| 61st through 90th day | All but \$256 a day | \$256/day | \$0 |
| 91st day and after: While using 60 lifetime reserve days | All but \$512 a day | \$512/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 through 100th day | All but \$128 a day | Up to \$128 a day | \$0 |
| 101st day and after | \$0 | \$0 | All costs |
| BLOOD | | | |
| First three pints | \$0 | 3 pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | \$0 | Balance |

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 \$135 of Medicare-Approved Amounts*** (Part B Deductible) | \$0 | \$0 | \$135 (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 three pints | \$0 | All costs | \$0 |
| Next \$135 of Medicare-Approved Amounts*** | \$0 | \$0 | \$135 (Part B Deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES — Tests For Diagnostic Services | 100% | \$0 | \$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.

** **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.

Note: Medicare deductibles and copayments are effective through December 31, 2008

PLAN I – *Continued*

Medicare (Parts A & B Continued)

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---------------|---|---|
| MEDICARE 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 \$135 of Medicare-Approved Amounts*** | \$0 | \$0 | \$135 (Part B Deductible) |
| Remainder of Medicare-Approved Amounts | 80% | 20% | \$0 |
| AT-HOME RECOVERY SERVICES -- NOT COVERED BY MEDICARE -- Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan | | | |
| Benefit for each visit | \$0 | Actual charges up to \$40 a visit | Balance |
| Number of visits covered (<i>must be received within eight weeks of last Medicare-Approved visit</i>) | \$0 | Up to the number of Medicare-Approved visits, not to exceed 7 each week | |
| Calendar year maximum | \$0 | \$1,600 | \$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 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 maximum |

*** Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with a triple asterisk), your Part B Deductible will have been met for the calendar year.

****However, Medicare may pay 50% of the Approved Amount for mental health services; then Plan payment increases to 50% of the Approved Amount.

PLAN J

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 \$1,024/ benefit period* | \$1,024* | \$0 |
| 61st through 90th day | All but \$256 a day | \$256/day | \$0 |
| 91st day and after: While using 60 lifetime reserve days | All but \$512 a day | \$512/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 through 100th day | All but \$128 a day | Up to \$128 a day | \$0 |
| 101st day and after | \$0 | \$0 | All costs |
| BLOOD | | | |
| First three pints | \$0 | 3 pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| HOSPICE CARE — Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited coinsurance for outpatient drugs and inpatient respite care | \$0 | Balance |

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 \$135 of Medicare-Approved Amounts*** (Part B Deductible) | \$0 | \$135 (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 three pints | \$0 | All costs | \$0 |
| Next \$135 of Medicare-Approved Amounts*** | \$0 | \$135 (Part B Deductible) | \$0 |
| Remainder of Medicare-Approved Amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES — Tests For Diagnostic Services | 100% | \$0 | \$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.

** **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.

Note: Medicare deductibles and copayments are effective through December 31, 2008

PLAN J – *Continued*

Medicare (Parts A & B Continued)

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---------------|---|---|
| MEDICARE 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 \$135 of Medicare-Approved Amounts*** | \$0 | \$135 (Part B Deductible) | \$0 |
| Remainder of Medicare-Approved Amounts | 80% | 20% | 0% |
| AT-HOME RECOVERY SERVICES -- NOT COVERED BY MEDICARE -- Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan | | | |
| Benefit for each visit | \$0 | Actual charges up to \$40 a visit | Balance |
| Number of visits covered (<i>must be received within eight weeks of last Medicare-Approved visit</i>) | 0 | Up to the number of Medicare-Approved visits, not to exceed 7 each week | |
| Calendar year maximum | \$0 | \$1,600 | \$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 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 maximum |
| PREVENTIVE MEDICAL CARE BENEFIT -- NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year | \$0 | \$120 | \$0 |
| Additional charges | \$0 | \$0 | All costs |

*** Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with a triple asterisk), your Part B Deductible will have been met for the calendar year.

**** However, Medicare may pay 50% of the Approved Amount for mental health services; then Plan payment increases to 50% of the Approved Amount.

LIMITATIONS AND EXCLUSIONS

Blue Cross and Blue Shield of North Carolina 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 is 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 and now have enrolled in this Medicare supplement plan;

If, within 12 months of enrolling in your first Medicare Advantage plan, you disenroll and choose Medicare Supplement Plans A, B, C, or F, or you are re-enrolling with Blue Cross and Blue Shield of North Carolina and this coverage is the same Medicare supplement plan you had prior to enrolling in Medicare Advantage coverage. *(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 your 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.