

# SUMMARY OF COVERAGE AND DISCLOSURE OF INFORMATION



## Basic Medicare Select (Senior Gold)

## Basic Medicare Supplement

## Extended Basic Medicare Supplement (Extended Basic Blue)

## Extended Basic Medicare Select Supplement (Extended Basic Select Blue)

## Medicare Supplement Plan with High Deductible (Plan F)

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

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

## Medicare Supplement Plan with \$20 and \$50 Copayments (Plan N)

The Commissioner of Commerce, State of Minnesota has established two categories of Medicare Supplements. The two categories, from most to least comprehensive, are the Extended Basic Medicare Supplement Plan and the Basic Medicare Supplement Plan. Select plan subscribers are required to use specific or preferred providers for certain benefits to be covered in Minnesota. Please note cost-sharing requirements for emergency services received from non-participating providers are the same as those received from participating providers. Select plan providers are available within Minnesota, and in all North Dakota, South Dakota, Iowa and Wisconsin counties that border Minnesota. If Select plan providers are not used, Blue Cross is not required to pay certain benefits.

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. **THIS CONTRACT MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THIS CONTRACT DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES 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. We will not cancel your coverage or refuse renewal based on your health. This contract is guaranteed renewable and you may renew your contract for further terms by paying your premium. Such payment must be made before the end of the grace period.
6. Your contract may be cancelled/non-renewed for nonpayment of premium subject to the grace period during which time the contract remains in force.
7. Upon reinstatement of this contract after suspension based on entitlement to medical assistance, there will be no additional waiting periods with respect to preexisting conditions and coverage will be substantially equivalent to the coverage in effect before the date of suspension. The premiums will also be at least favorable to the contract holder as the premium that applied had the coverage not been suspended.

8. If you are a disabled Medicare beneficiary and covered under a group health plan, you may not need this contract. The benefits and premiums under this contract can be suspended for up to 24 months during your enrollment in a group health plan. You must request this suspension in writing. When you lose your group health plan coverage, this contract can be reinstated. You must notify us in writing within 90 days of losing group health plan coverage if you want to be reinstated.
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. Please note cost-sharing requirements for emergency services received from nonparticipating providers are the same as those received from participating providers. 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. For services received outside of the United States, please see benefit charts in Section 2 for coverage details.
11. Notice: This contract does not cover prescription drugs. Prescription drugs can be a very high percentage of your medical expenses. Coverage for prescription drugs may be available to you by retaining existing coverage you may have or by enrolling in Medicare Part D.
12. 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.
13. Contact the Minnesota Department of Commerce for information about other medical insurance products currently available in Minnesota.

You may contact the Minnesota Department of Commerce at any time at:

Minnesota Department of Commerce

Main Office, Golden Rule Building

85 7th Place East, Suite 280

St. Paul, MN 55101

Telephone: 651-539-1500 (local)

651-539-1600 (complaints)

1-800-657-3602 (Greater MN only)

Email: [consumer.protection@state.mn.us](mailto:consumer.protection@state.mn.us)

Website: <https://mn.gov/commerce/about/contact/>

Mail written complaints to:

Minnesota Department of Commerce

Attn: Consumer Services Center

85 7th Place East, Suite 280

St. Paul, MN 55101

On-line complaints: <https://mn.gov/commerce/consumers/file-a-comp>

## I. RATE INFORMATION

### 2022 Monthly Premiums

Plan	Tobacco - Free	Standard
<b>Basic Medicare Select (Senior Gold)</b>		
1. Your cost	\$231.15	\$277.30
2. Medicare Part A deductible	\$36.00	\$36.00
3. Medicare Part B deductible*	\$17.50	\$17.50
4. Coverage of 100% Medicare Part B excess charges	\$1.00	\$1.00
5. Optional benefits: Preventive care	\$4.00	\$4.00
<b>Total including all optional benefits =</b>	<b>\$289.65</b>	<b>\$335.80</b>

Plan	Tobacco - Free	Standard
<b>Basic Medicare Supplement (Basic Medicare Blue<sup>SM</sup>)</b>		
1. Your cost	\$204.40	\$237.95
2. Medicare Part A deductible	\$36.00	\$36.00
3. Medicare Part B deductible*	\$17.50	\$17.50
4. Coverage of 100% Medicare Part B excess charges	\$1.00	\$1.00
5. Optional benefits: Preventive care	\$4.00	\$4.00
<b>Total including all optional benefits =</b>	<b>\$262.90</b>	<b>\$296.45</b>

Plan	Tobacco - Free	Standard
<b>Extended Basic Medicare Select (Extended Basic Select Blue<sup>SM</sup>)</b>	\$281.50	\$337.75
<b>Extended Basic Medicare Select (Extended Basic Select Blue<sup>SM</sup>) Without coverage of Medicare Part B annual deductible</b>	\$264.00	\$320.25
<b>Extended Basic Medicare Supplement (Extended Basic Blue<sup>SM</sup>)*</b>	\$290.70	\$348.80
<b>Extended Basic Medicare Supplement (Extended Basic Blue) Without coverage of Medicare Part B annual deductible</b>	\$273.20	\$331.30
<b>Medicare Supplement Plan with High Deductible (Plan F)*</b>	\$82.15	\$98.60
<b>Medicare Supplement Plan with High Deductible (Plan F) Without coverage of Medicare Part B annual deductible</b>	\$64.65	\$81.10
<b>Medicare Supplement Plan with 75 Percent Coverage (Plan L)</b>	\$188.15	\$220.55
<b>Medicare Supplement Plan with \$20 and \$50 Copayments (Plan N)</b>	\$189.60	\$227.55
<b>Medicare Supplement Plan with 50 Percent Coverage (Plan K)</b>	\$132.30	\$154.05

\*Coverage of the Medicare Part B annual deductible is not available to a newly eligible individual first eligible for Medicare on or after January 1, 2020.

## II. Outline of Medicare Supplement Coverage

	Basic Medicare Select (Senior Gold)	Basic Medicare Supplement (Basic Medicare Blue <sup>SM</sup> )	Extended Basic Medicare Select (Extended Basic Select Blue <sup>SM</sup> )	Extended Basic Medicare Supplement (Extended Basic Blue <sup>SM</sup> )
Maximum Out of Pocket			\$1,000	\$1,000
Medicare Part A Deductible	100%**	100%**	100%	100%
Medicare Part A Hospitalization Coinsurance	100%	100%	100%	100%
Medicare Part A Skilled Nursing Facility Coinsurance	100%	100%	100%	100%
Medicare Part B Deductible*	100%**	100%**	100%	100%
Medicare Part B excess charges	100%**	100%**	100%	100%
Medicare Part B Medical Expenses Coinsurance	100%	100%	100%	100%
Blood: First 3 Pints Each Year	100%	100%	100%	100%
Preventive care (Up to \$120 Non-Medicare covered)	100%**	100%**	100%	100%
Foreign Travel Emergency	80%	80%	80%	80%
Coverage while in a Foreign Country			80%	80%

\*Coverage of the Medicare Part B annual deductible is not available to a newly eligible individual first eligible for Medicare on or after January 1, 2020.

\*\*This coverage is available as an optional rider.

Note: Plans with Maximum Out of Pocket costs will have 100% coverage after that amount is met.

Grey shaded area means coverage is not provided for that plan and benefit.

	Medicare Supplement Plan with High Deductible (Plan F)**	Medicare Supplement Plan with 50 Percent Coverage (Plan K)	Medicare Supplement Plan with 75 Percent Coverage (Plan L)	Medicare Supplement Plan with \$20 and \$50 Copayments (Plan N)***
Maximum Out of Pocket		\$5,880	\$2,940	
Medicare Part A Deductible	100%	50%	75%	100%
Medicare Part A Hospitalization Coinsurance	100%	100%	100%	100%
Medicare Part A Skilled Nursing Facility Coinsurance	100%	50%	75%	100%
Medicare Part B Deductible*	100%			
Medicare Part B excess charges (100%)	20%			20%
Medicare Part B Medical Expenses Coinsurance	100%	50%	75%	100%
Blood: First 3 Pints Each Year	100%	100%	100%	100%
Preventive care (Up to \$120 Non – Medicare covered)				
Foreign Travel Emergency	100%			80%
Coverage while in a Foreign Country				

\*Coverage of the Medicare Part B annual deductible is not available to a newly eligible individual first eligible for Medicare on or after January 1, 2020.

\*\*Benefits from the High Deductible Coverage Plan 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 contract. These expenses include the Medicare deductible for Part A.

\*\*\*Medicare Supplement Plan with \$20 and \$50 Copayments (Plan N) coverage applies after \$20 copay for office visits and up to \$50 for emergency when applicable.

Note: Plans with Maximum Out of Pocket costs will have 100% coverage after that amount is met.

Grey shaded area means coverage is not provided for that plan and benefit.

## Basic Medicare Select (Senior Gold) Coverage

Services	Medicare Pays	Plan Pays	You Pay
<b>Inpatient Hospital Services</b>			
First 60 days	100% after Part A deductible	100% Part A coinsurance	Optional Rider or Part A deductible
Days 61 – 90	100% after Part A coinsurance		
Days 91 – 150 while using your lifetime reserve days	\$0		
Additional 365 days	\$0		
Beyond additional 365 days	\$0		
<b>Skilled Nursing Care</b>			
First 20 days	100%	\$0	\$0
Days 21–100	100% after Part A coinsurance	100% Part A coinsurance	\$0
Days 101 – 120	\$0	\$0	100%
<b>Hospice</b> (must be provided by a Medicare certified hospice)			
Hospice care and services	100%	100% remaining	\$0
Outpatient drugs	100%	100% remaining	\$0
Inpatient respite care	100%	100% remaining	\$0
<b>Home Health Care</b> (medically necessary)			
Skilled care services/ medical supplies	100%	\$0	\$0
Durable medical equipment	80% after Part B deductible	20% Part B coinsurance	Optional Rider* or Part B deductible
<b>Medical Expenses</b>			
Hospital treatment	80% after Part B deductible	20% Part B coinsurance	Optional Rider* or Part B deductible
Medical/surgical services			
Therapy			
Diagnostic testing			
Medicare Part B excess charges			Optional Rider or Part B excess charges

<b>Blood</b>			
First 3 pints per year	\$0	100%	\$0
Additional pints of blood	80%	20%	\$0
<b>Foreign Travel</b> (must be medically necessary for hospital, medical, and supply expenses):			
Emergency care only	\$0	80%	20%
Non – Emergency care	\$0	\$0	100%
<b>Preventive Services</b>			
Medicare approved preventive services**	100%	\$0	\$0
Non – Medicare covered preventive services	\$0	\$120 with Optional Rider or \$0 without	Optional Rider and charges above \$120 or all charges
<b>Additional Benefits</b>			
Cancer Screening	\$0	100%	\$0
Immunizations not otherwise covered under Medicare Part D	\$0	100%	\$0
Outpatient Behavioral Health Treatment Program	\$0	80%	20%
Residential Behavioral Health Treatment Program			
Management and Treatment of Diabetes			
Treatment of Diagnosed Lyme Disease			
Court-Ordered Mental Health Services			
Phenylketonuria			
Reconstructive Surgery			
Scalp Hair Prosthesis (Wigs)			
Temporomandibular Joint Disorder (TMJ)			
Ventilator-Dependent Persons			

\*Coverage of the Medicare Part B annual deductible is not available to a newly eligible individual first eligible for Medicare on or after January 1, 2020.

\*\*Approved preventive services: bone mass measurement, colorectal screening exams, immunizations, pap smears and pelvic exams, prostate cancer screening exam, Welcome to Medicare exam and Annual Wellness Visits.

## Basic Medicare Supplement Coverage

Services	Medicare Pays	Plan Pays	You Pay
<b>Inpatient Hospital Services</b>			
First 60 days	100% after Part A deductible	100% Part A coinsurance	Optional Rider or Part A deductible
Days 61 – 90	100% after Part A coinsurance		
Days 91 – 150 while using your lifetime reserve days	\$0		
Additional 365 days	\$0		
Beyond additional 365 days	\$0		
<b>Skilled Nursing Care</b>			
First 20 days	100%	\$0	\$0
Days 21 – 100	100% after Part A coinsurance	100% Part A coinsurance	\$0
Days 101 – 120	\$0	\$0	100%
<b>Hospice</b> (must be provided by a Medicare certified hospice)			
Hospice care and services	100%	100% remaining	\$0
Outpatient drugs	100%	100% remaining	\$0
Inpatient respite care	100%	100% remaining	\$0
<b>Home Health Care</b> (medically necessary)			
Skilled care services/ medical supplies	100%	\$0	\$0
Durable medical equipment	80% after Part B deductible	20% Part B coinsurance	Optional Rider* or Part B deductible
Medicare Part B excess charges			Optional Rider or Part B excess charges
<b>Medical Expenses</b>			
Hospital treatment	80% after Part B deductible	20% Part B coinsurance	Optional Rider* or Part B deductible
Medical/surgical services			
Therapy			
Diagnostic testing			



<b>Blood</b>			
First 3 pints per year	\$0	100%	\$0
Additional pints of blood	80%	20%	\$0
<b>Foreign Travel</b> (must be medically necessary for hospital, medical, and supply expenses)			
Emergency care only	\$0	80%	20%
Non – Emergency care	\$0	\$0	100%
<b>Preventive Services</b>			
Medicare approved preventive services**	100%	\$0	\$0
Non – Medicare covered preventive services	\$0	\$120 with Optional Rider or \$0 without	Optional Rider and charges above \$120 or all charges
<b>Additional Benefits</b>			
Cancer Screening	\$0	100%	\$0
Immunizations not otherwise covered under Medicare Part D	\$0	100%	\$0
Outpatient Behavioral Health Treatment Program	\$0	80%	20%
Residential Behavioral Health Treatment Program			
Management and Treatment of Diabetes			
Treatment of Diagnosed Lyme Disease			
Court – Ordered Mental Health Services			
Phenylketonuria			
Reconstructive Surgery			
Scalp Hair Prosthesis (Wigs)			
Temporomandibular Joint Disorder (TMJ)			
Ventilator-Dependent Persons			

\*Coverage of the Medicare Part B annual deductible is not available to a newly eligible individual first eligible for Medicare on or after January 1, 2020.

\*\*Approved preventive services: bone mass measurement, colorectal screening exams, immunizations, pap smears and pelvic exams, prostate cancer screening exam, Welcome to Medicare exam and Annual Wellness Visits.

**Extended Basic Medicare Select (Extended Basic Select Blue<sup>SM</sup>) Coverage**

<b>Services</b>	<b>Medicare Pays</b>	<b>Plan Pays</b>	<b>You Pay</b>
<b>Inpatient Hospital Services</b>			
First 60 days	100% after Part A deductible	100% Part A deductible and coinsurance	\$0
Days 61 – 90	100% after Part A coinsurance		
Days 91 – 150 while using your lifetime reserve days	\$0		
Additional 365 days	\$0		
Beyond additional 365 days	\$0		
<b>Skilled Nursing Care</b>			
First 20 days	100%	\$0	\$0
Days 21 – 100	100% after Part A coinsurance	100% Part A coinsurance	\$0
Days 101 – 120	\$0	80%	20%
<b>Hospice</b> (must be provided by a Medicare certified hospice)			
Hospice care and services	100%	100%	\$0
Outpatient drugs	100%	100%	\$0
Inpatient respite care	100%	100%	\$0
<b>Home Health Care</b> (medically necessary)			
Skilled care services/ medical supplies	100%	\$0	\$0
Durable medical equipment	80% after Part B deductible	20% Part B coinsurance & deductible*	Part B deductible*
<b>Medical Expenses</b>			
Hospital treatment	80% after Part B deductible	20% coinsurance & deductible*	Part B deductible*
Medical/surgical services			
Therapy			
Diagnostic testing			

<b>Blood</b>			
First 3 pints per year	\$0	100%	\$0
Additional pints of blood	80%	20%	\$0
<b>Foreign Travel</b> (must be medically necessary for hospital, medical, and supply expenses)			
Emergency care only	\$0	80%	20%
Non – Emergency care	\$0	80%	20%
<b>Preventive Services</b>			
Medicare approved preventive services**	100%	\$0	\$0
Non – Medicare covered preventive services	\$0	\$120	charges above \$120
<b>Additional Benefits</b>			
Cancer Screening	\$0	100%	\$0
Immunizations not otherwise covered under Medicare Part D	\$0	100%	\$0
Outpatient Behavioral Health Treatment Program	\$0	80%	20%
Residential Behavioral Health Treatment Program			
Management and Treatment of Diabetes			
Treatment of Diagnosed Lyme Disease			
Court – Ordered Mental Health Services			
Phenylketonuria			
Reconstructive Surgery			
Scalp Hair Prosthesis (Wigs)			
Temporomandibular Joint Disorder (TMJ)			
Ventilator – Dependent Persons			

## Extended Basic Medicare Supplement (Extended Basic Blue) Coverage

Services	Medicare Pays	Plan Pays	You Pay
<b>Inpatient Hospital Services</b>			
First 60 days	100% after Part A deductible	100% Part A deductible and coinsurance	\$0
Days 61 – 90	100% after Part A coinsurance		
Days 91 – 150 while using your lifetime reserve days	\$0		
Additional 365 days	\$0		
Beyond additional 365 days	\$0		
<b>Skilled Nursing Care</b>			
First 20 days	100%	\$0	\$0
Days 21 – 100	100% after Part A coinsurance	100% Part A coinsurance	\$0
Days 101 – 120	\$0	80%	20%
<b>Hospice</b> (must be provided by a Medicare certified hospice)			
Hospice care and services	100%	100% remaining	\$0
Outpatient drugs	100%	100% remaining	\$0
Inpatient respite care	100%	100% remaining	\$0
<b>Home Health Care</b> (medically necessary)			
Skilled care services/ medical supplies	100%	\$0	\$0
Durable medical equipment	80% after Part B deductible	20% Part B coinsurance & deductible*	Part B deductible*
<b>Medical Expenses</b>			
Hospital treatment	80% after Part B deductible	20% coinsurance & deductible*	Part B deductible*
Medical/surgical services			
Therapy			
Diagnostic testing			

<b>Blood</b>			
First 3 pints per year	\$0	100%	\$0
Additional pints of blood	80%	20%	\$0
<b>Foreign Travel</b> (must be medically necessary for hospital, medical, and supply expenses)			
Emergency care only	\$0	80%	20%
Non – Emergency care	\$0	80%	20%
<b>Preventive Services</b>			
Medicare approved preventive services**	100%	\$0	\$0
Non – Medicare covered preventive services	\$0	\$120	charges above \$120
<b>Additional Benefits</b>			
Cancer Screening	\$0	100%	\$0
Immunizations not otherwise covered under Medicare Part D	\$0	100%	\$0
Outpatient Behavioral Health Treatment Program	\$0	80%	20%
Residential Behavioral Health Treatment Program			
Management and Treatment of Diabetes			
Treatment of Diagnosed Lyme Disease			
Court – Ordered Mental Health Services			
Phenylketonuria			
Reconstructive Surgery			
Scalp Hair Prosthesis (Wigs)			
Temporomandibular Joint Disorder (TMJ)			
Ventilator – Dependent Persons			

\*Coverage of the Medicare Part B annual deductible is not available to a newly eligible individual first eligible for Medicare on or after January 1, 2020.

\*\*Approved preventive services: 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 High Deductible (Plan F)

Services	Medicare Pays	Plan Pays	You Pay
<b>Inpatient Hospital Services</b>			
First 60 days	100% after Part A deductible	100% Part A deductible and coinsurance	\$0
Days 61 – 90	100% after Part A coinsurance		
Days 91 – 150 while using your lifetime reserve days	\$0		
Additional 365 days	\$0		
Beyond additional 365 days	\$0	\$0	100%
<b>Skilled Nursing Care</b>			
First 20 days	100%	\$0	\$0
Days 21 – 100	100% after Part A coinsurance	100% Part A coinsurance	\$0
Days 101 – 120	\$0	\$0	100%
<b>Hospice</b> (must be provided by a Medicare certified hospice)			
Hospice care and services	100%	100% remaining	\$0
Outpatient drugs	100%	100% remaining	\$0
Inpatient respite care	100%	100% remaining	\$0
<b>Home Health Care</b> (medically			
Skilled care services/ medical supplies	100%	\$0	\$0
Durable medical equipment	80% after Part B deductible	20% Part B coinsurance & deductible*	Part B deductible*
<b>Medical Expenses</b>			
Hospital treatment	80% after Part B deductible	20% Part B coinsurance & deductible*	Part B deductible*
Medical/surgical services			
Therapy			
Diagnostic testing			

<b>Blood</b>			
First 3 pints per year	\$0	100%	\$0
Additional pints of blood	80%	20%	\$0
<b>Foreign Travel</b> (must be medically necessary for hospital, medical, and supply expenses)			
Emergency care only	\$0	100%	\$0
Non – Emergency care	\$0	\$0	100%
<b>Preventive Services</b>			
Medicare approved preventive services**	100%	\$0	\$0
Non – Medicare covered preventive services	\$0	\$0	100%
<b>Additional Benefits</b>			
Cancer Screening	\$0	100%	\$0
Immunizations not otherwise covered under Medicare Part D	\$0	100%	\$0
Outpatient Behavioral Health Treatment Program	\$0	80%	20%
Residential Behavioral Health Treatment Program			
Management and Treatment of Diabetes			
Treatment of Diagnosed Lyme Disease			
Court-Ordered Mental Health Services			
Phenylketonuria			
Reconstructive Surgery			
Scalp Hair Prosthesis (Wigs)			
Temporomandibular Joint Disorder (TMJ)			
Ventilator – Dependent Persons			

\*Coverage of the Medicare Part B annual deductible is not available to a newly eligible individual first eligible for Medicare on or after January 1, 2020.

\*\*Approved preventive services: bone mass measurement, colorectal screening exams, immunizations, pap smears and pelvic exams, prostate cancer screening exam, Welcome to Medicare exam and Annual Wellness Visits.

Note: Benefits from the High Deductible Coverage Plan 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 contract. These expenses include the Medicare deductible for Part A.

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

Services	Medicare Pays	Plan Pays	You Pay
<b>Inpatient Hospital Services</b>			
First 60 days	100% after Part A deductible	50% Part A deductible and 100% coinsurance	50% Part A deductible
Days 61 – 90	100% after Part A coinsurance		
Days 91 – 150 while using your lifetime reserve days	\$0		
Additional 365 days	\$0		
Beyond additional 365 days	\$0	\$0	100%
<b>Skilled Nursing Care</b>			
First 20 days	100%	\$0	\$0
Days 21 – 100	100% after Part A coinsurance	50% Part A coinsurance	50% Part A coinsurance
Days 101 – 120	\$0	\$0	100%
<b>Hospice</b> (must be provided by a Medicare certified hospice)			
Hospice care and services	100%	50% remaining	50% remaining
Outpatient drugs	100%	50% remaining	50% remaining
Inpatient respite care	100%	50% remaining	50% remaining
<b>Home Health Care</b> (medically necessary)			
Skilled care services/ medical supplies	100%	\$0	\$0
Durable medical equipment	80% after Part B deductible	10% Part B coinsurance	10% Part B coinsurance 100% Part B deductible
<b>Medical Expenses</b>			
Hospital treatment	80% after Part B deductible	10% coinsurance	10% coinsurance & 100% Part B deductible
Medical/surgical services			
Therapy			
Diagnostic testing			



<b>Blood</b>			
First 3 pints per year	\$0	50%	50%
Additional pints of blood	80%	10%	10%
<b>Foreign Travel</b> (must be medically necessary for hospital, medical, and supply expenses)			
Emergency care only	\$0	\$0	100%
Non – Emergency care	\$0	\$0	100%
<b>Preventive Services</b>			
Medicare approved preventive services**	100%	\$0	\$0
Non – Medicare covered preventive services	\$0	\$0	100%
<b>Additional Benefits</b>			
Cancer Screening	\$0	100%	\$0
Immunizations not otherwise covered under Medicare Part D	\$0	100%	\$0
Outpatient Behavioral Health Treatment Program	\$0	50%	50%
Residential Behavioral Health Treatment Program			
Management and Treatment of Diabetes			
Treatment of Diagnosed Lyme Disease			
Court – Ordered Mental Health Services			
Phenylketonuria			
Reconstructive Surgery			
Scalp Hair Prosthesis (Wigs)			
Temporomandibular Joint Disorder (TMJ)			
Ventilator – Dependent Persons			

\*\*Approved preventive services: bone mass measurement, colorectal screening exams, immunizations, pap smears and pelvic exams, prostate cancer screening exam, Welcome to Medicare exam and Annual Wellness Visits.

Note: There is a \$6,220 annual out-of-pocket maximum in 2021 after which eligible Medicare Part A and B expenses are paid at 100%. This out-of-pocket amount may be adjusted for inflation annually.

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

Services	Medicare Pays	Plan Pays	You Pay
<b>Inpatient Hospital Services</b>			
First 60 days	100% after Part A deductible	75% Part A deductible and 100% coinsurance	25% Part A deductible
Days 61 – 90	100% after Part A coinsurance		
Days 91 – 150 while using your lifetime reserve days	\$0		
Additional 365 days	\$0		
Beyond additional 365 days	\$0	\$0	100%
<b>Skilled Nursing Care</b>			
First 20 days	100%	\$0	\$0
Days 21 – 100	100% after Part A coinsurance	75% Part A coinsurance	25% Part A coinsurance
Days 101 – 120	\$0	\$0	100%
<b>Hospice</b> (must be provided by a Medicare certified hospice)			
Hospice care and services	100%	75% remaining	25% remaining
Outpatient drugs	100%	75% remaining	25% remaining
Inpatient respite care	100%	75% remaining	25% remaining
<b>Home Health Care</b> (medically necessary)			
Skilled care services/ medical supplies	100%	\$0	\$0
Durable medical equipment	80% after Part B deductible	15% Part B coinsurance	5% Part B coinsurance 100% Part B deductible
<b>Medical Expenses</b>			
Hospital treatment	80% after Part B deductible	15% coinsurance	5% coinsurance & 100% Part B deductible
Medical/surgical services			
Therapy			
Diagnostic testing			

<b>Blood</b>			
First 3 pints per year	\$0	75%	25%
Additional pints of blood	80%	15%	5%
<b>Foreign Travel</b> (must be medically necessary for hospital, medical, and supply expenses)			
Emergency care only	\$0	\$0	100%
Non – Emergency care	\$0	\$0	100%
<b>Preventive Services</b>			
Medicare approved preventive services**	100%	\$0	\$0
Non – Medicare covered preventive services	\$0	\$0	100%
<b>Additional Benefits</b>			
Cancer Screening	\$0	100%	\$0
Immunizations not otherwise covered under Medicare Part D	\$0	100%	\$0
Outpatient Behavioral Health Treatment Program	\$0	75%	25%
Residential Behavioral Health Treatment Program			
Management and Treatment of Diabetes			
Treatment of Diagnosed Lyme Disease			
Court – Ordered Mental Health Services			
Phenylketonuria			
Reconstructive Surgery			
Scalp Hair Prosthesis (Wigs)			
Temporomandibular Joint Disorder (TMJ)			
Ventilator – Dependent Persons			

\*\*Approved preventive services: bone mass measurement, colorectal screening exams, immunizations, pap smears and pelvic exams, prostate cancer screening exam, Welcome to Medicare exam and Annual Wellness Visits.

Note: There is a \$3,110 annual out-of-pocket maximum in 2021 after which eligible Medicare Part A and B expenses are paid at 100%. This out-of-pocket amount may be adjusted for inflation annually.

## Medicare Supplement Plan with \$20 and \$50 Copayments (Plan N)

Services	Medicare Pays	Plan Pays	You Pay
<b>Inpatient Hospital Services</b>			
First 60 days	100% after Part A deductible	100% Part A deductible and coinsurance	\$0
Days 61 – 90	100% after Part A coinsurance		
Days 91 – 150 while using your lifetime reserve days	\$0		
Additional 365 days	\$0		
Beyond additional 365 days	\$0	\$0	100%
<b>Skilled Nursing Care</b>			
First 20 days	100%	\$0	\$0
Days 21 – 100	100% after Part A coinsurance	100% Part A coinsurance	\$0
Days 101 – 120	\$0	\$0	100%
<b>Hospice</b> (must be provided by a Medicare certified hospice)			
Hospice care and services	100%	100% remaining	\$0
Outpatient drugs	100%	100% remaining	\$0
Inpatient respite care	100%	100% remaining	\$0
<b>Home Health Care</b> (medically necessary)			
Skilled care services/ medical supplies	100%	\$0	\$0
Durable medical equipment	80% after Part B deductible	20% Part B coinsurance	Part B deductible
<b>Medical Expenses</b>			
Hospital treatment	80% after Part B deductible & copayment*	20% coinsurance	Part B deductible & copayment*
Medical/surgical services			
Therapy			
Diagnostic testing			

<b>Blood</b>			
First 3 pints per year	\$0	100%	\$0
Additional pints of blood	80%	20%	\$0
<b>Foreign Travel</b> (must be medically necessary for hospital, medical, and supply expenses)			
Emergency care only	\$0	80%	20%
Non – Emergency care	\$0	\$0	100%
<b>Preventive Services</b>			
Medicare approved preventive services**	100%	\$0	\$0
Non – Medicare covered preventive services	\$0	\$0	100%
<b>Additional Benefits</b>			
Cancer Screening	\$0	100%	\$0
Immunizations not otherwise covered under Medicare Part D	\$0	100%	\$0
Outpatient Behavioral Health Treatment Program	\$0	80%	20%
Residential Behavioral Health Treatment Program			
Management and Treatment of Diabetes			
Treatment of Diagnosed Lyme Disease			
Court – Ordered Mental Health Services			
Phenylketonuria			
Reconstructive Surgery			
Scalp Hair Prosthesis (Wigs)			
Temporomandibular Joint Disorder (TMJ)			
Ventilator – Dependent Persons			

\* Medicare Supplement Plan with \$20 and \$50 Copayments (Plan N) coverage applies after \$20 copay for office visits and up to \$50 for emergency when applicable. The emergency copay is waived if you are admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

\*\*Approved preventive services: bone mass measurement, colorectal screening exams, immunizations, pap smears and pelvic exams, prostate cancer screening exam, Welcome to Medicare exam and Annual Wellness Visits.

### III. 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.

Medical underwriting is prohibited during periods of guarantee issue and open enrollment and as such it is not a material representation to omit answers to questions regarding medical conditions and health history on the application for purposes of contract rescission or claim denial. Minnesota does not allow post claim underwriting.

In addition, there are limitations on denials, conditions and pricing of coverage.

#### 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 contract'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 982801  
El Paso, TX 79998-2801

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 suspension in coverage.

## **D. Notice of Noncoverage**

**This contract may not cover all of your medical expenses beyond those covered by Medicare. This contract does not cover all skilled nursing home care expenses and does not cover custodial or residential nursing care. Read your contract carefully to determine which nursing home facilities and expenses are covered by your contract.**

## **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. You do not need to complete health history questions if you are eligible for guarantee issue (including the six (6) month open – enrollment window following your Part B effective date). 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. **This section is not applicable during open enrollment and guaranteed issue periods when medical underwriting is prohibited.**

#### **G. Grievance Procedures (Basic Medicare Select and Extended 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.

For purposes of this item, complaints need not be in writing.

You may contact the Minnesota Department of Commerce at any time at:

Minnesota Department of Commerce

Main Office, Golden Rule Building

85 7th Place East, Suite 280

St. Paul, MN 55101

Telephone: 651-539-1500 (local)

651-539-1600 (complaints)

1-800-657-3602 (Greater MN only)

Email: [consumer.protection@state.mn.us](mailto:consumer.protection@state.mn.us)

Website: <https://mn.gov/commerce/about/contact/>

Mail written complaints to:

Minnesota Department of Commerce

Attn: Consumer Services Center

85 7th Place East, Suite 280

St. Paul, MN 55101

On-line complaints: <https://mn.gov/commerce/consumers/file-a-complaint/>

#### **H. Suspension Based on Entitlement to Medical Assistance**

If you are a disabled Medicare beneficiary and covered under a group health plan, you may not need this contract.

The benefits and premiums under this contract can be suspended for up to 24 months during your enrollment in a group health plan. You must request this suspension in writing. When you lose your group health plan coverage, this contract can be reinstated. You must notify us in writing within 90 days of losing group health plan coverage if you want to be reinstated.

**NOTICE OF NONDISCRIMINATION PRACTICES**  
**Effective July 18, 2016**

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: [Civil.Rights.Coord@bluecrossmn.com](mailto:Civil.Rights.Coord@bluecrossmn.com)
- by mail at: Nondiscrimination Civil Rights Coordinator  
Blue Cross and Blue Shield of Minnesota and Blue Plus  
M495  
PO Box 64560  
Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- by phone at:  
1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Room 509F  
HHH Building  
Washington, DC 20201

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association.

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိကညိကျိန်ဒီး, တၢ်ကဟ့ၣ်နၢကျိၣ်တၢ်မၤစၢၤကလိတဖၣ်န့ၣ်လီၤ. ကိး 1-866-251-6744 လၢ TTY  
အဂီၢ်, ကိး 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي  
اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສໍາລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមែន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojí éí béesh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jí' béesh bee hodíílnih.

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