



This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

**Blue Cross and Blue Shield of Illinois does not offer those plans shaded in gray below.**

**BASIC BENEFITS:**

- Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses – Part B coinsurance (generally 20% of Medicare-approved expenses), or copayments for hospital outpatient services. Plans K<sup>3</sup>, L<sup>3</sup> and N require insureds to pay a portion of Part B coinsurance or copayments.
- Blood – First 3 pints of blood each year.
- Hospice – Part A coinsurance.

<b>A</b>	Basic Benefits, including 100% Part B Coinsurance						
<b>B</b>	Basic Benefits, including 100% Part B Coinsurance		Part A Deductible				
<b>D</b>	Basic Benefits, including 100% Part B Coinsurance	Skilled Nursing Facility Coinsurance	Part A Deductible			Foreign Travel Emergency	
<b>G</b> <b>G<sup>1</sup></b>	Basic Benefits, including 100% Part B Coinsurance	Skilled Nursing Facility Coinsurance	Part A Deductible		Part B Excess (100%)	Foreign Travel Emergency	
<b>K<sup>3</sup></b>	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	50% Skilled Nursing Facility Coinsurance	50% Part A Deductible				Out-of-pocket limit <sup>4</sup> \$6,620; paid at 100% after limit reached
<b>L<sup>3</sup></b>	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	75% Skilled Nursing Facility Coinsurance	75% Part A Deductible				Out-of-pocket limit <sup>4</sup> \$3,310; paid at 100% after limit reached
<b>M</b>	Basic Benefits, including 100% Part B Coinsurance	Skilled Nursing Facility Coinsurance	50% Part A Deductible			Foreign Travel Emergency	
<b>N</b>	Basic Benefits, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER	Skilled Nursing Facility Coinsurance	Part A Deductible			Foreign Travel Emergency	
Only available if Medicare-eligible before 2020							
<b>C</b>	Basic Benefits, including 100% Part B Coinsurance	Skilled Nursing Facility Coinsurance	Part A Deductible	Part B Deductible		Foreign Travel Emergency	
<b>F</b> <b>F<sup>1</sup></b>	Basic Benefits, including 100% Part B Coinsurance <sup>1</sup>	Skilled Nursing Facility Coinsurance	Part A Deductible	Part B Deductible	Part B Excess (100%)	Foreign Travel Emergency	

- <sup>1</sup> These high deductible plans pay the same benefits as Plans F and G after one has paid a calendar-year \$2,490 deductible. Benefits from High Deductible Plans F and G will not begin until out-of-pocket expenses are \$2,490. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.
- <sup>3</sup> Plans K and L provide for different cost-sharing for items and services than the other plans we offer. Amounts that count towards the annual limit are noted with an asterisk (\*). Once you reach the annual limit, the plan pays 100% of the Medicare copayments and coinsurance 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.
- <sup>4</sup> The out-of-pocket annual limit will increase each year for inflation.

## Monthly Premium Rates effective April 1, 2022

Rates shown are for Illinois residents living in Cook, DuPage, Kane, Lake, McHenry or Will Counties only.

If you're an Illinois resident living outside of Cook, DuPage, Kane, Lake, McHenry or Will County, please call the toll-free number that appears on the application and throughout the information packet.

<b>Age 65</b>				
	<b>FEMALE</b>		<b>MALE</b>	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$116.86	\$106.24	\$134.33	\$122.12
<b>F</b>	\$159.81	\$145.29	\$183.70	\$167.00
<b>G</b>	\$137.96	\$125.42	\$158.57	\$144.16
<b>N</b>	\$114.58	\$104.17	\$131.71	\$119.74

<b>Age 66</b>				
	<b>FEMALE</b>		<b>MALE</b>	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$116.86	\$106.24	\$134.33	\$122.12
<b>F</b>	\$159.81	\$145.29	\$183.70	\$167.00
<b>G</b>	\$137.96	\$125.42	\$158.57	\$144.16
<b>N</b>	\$114.58	\$104.17	\$131.71	\$119.74

<b>Age 67</b>				
	<b>FEMALE</b>		<b>MALE</b>	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$116.86	\$106.24	\$134.33	\$122.12
<b>F</b>	\$159.81	\$145.29	\$183.70	\$167.00
<b>G</b>	\$137.96	\$125.42	\$158.57	\$144.16
<b>N</b>	\$114.58	\$104.17	\$131.71	\$119.74

## Age 68

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$123.05	\$111.87	\$141.43	\$128.58
F	\$166.18	\$151.08	\$191.01	\$173.65
G	\$145.09	\$131.90	\$166.77	\$151.61
N	\$120.75	\$109.78	\$138.80	\$126.19

## Age 69

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$129.93	\$118.12	\$149.34	\$135.77
F	\$173.96	\$158.15	\$199.95	\$181.78
G	\$153.02	\$139.11	\$175.89	\$159.90
N	\$127.80	\$116.19	\$146.91	\$133.56

## Age 70

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$136.80	\$124.37	\$157.24	\$142.95
F	\$182.44	\$165.86	\$209.71	\$190.65
G	\$161.74	\$147.04	\$185.91	\$169.01
N	\$134.86	\$122.60	\$155.01	\$140.92

## Age 71

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$143.67	\$130.61	\$165.14	\$150.13
F	\$191.64	\$174.22	\$220.27	\$200.25
G	\$170.46	\$154.97	\$195.93	\$178.12
N	\$141.91	\$129.01	\$163.11	\$148.29

## Age 72

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$149.86	\$136.24	\$172.26	\$156.60
F	\$200.83	\$182.58	\$230.84	\$209.86
G	\$179.19	\$162.90	\$205.96	\$187.24
N	\$148.96	\$135.42	\$171.22	\$155.66

## Age 73

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$156.04	\$141.86	\$179.36	\$163.06
F	\$209.31	\$190.29	\$240.60	\$218.73
G	\$187.11	\$170.10	\$215.07	\$195.52
N	\$156.02	\$141.84	\$179.33	\$163.03

## Age 74

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$161.54	\$146.86	\$185.69	\$168.81
F	\$217.81	\$198.01	\$250.34	\$227.59
G	\$195.04	\$177.31	\$224.19	\$203.81
N	\$163.07	\$148.25	\$187.44	\$170.40

## Age 75

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$167.04	\$151.86	\$192.01	\$174.56
F	\$226.29	\$205.72	\$260.10	\$236.46
G	\$202.97	\$184.52	\$233.29	\$212.09
N	\$170.12	\$154.66	\$195.54	\$177.77

## Age 76

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$171.86	\$156.24	\$197.53	\$179.58
F	\$234.06	\$212.79	\$269.04	\$244.59
G	\$210.90	\$191.73	\$242.41	\$220.38
N	\$176.29	\$160.27	\$202.63	\$184.21

## Age 77

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$176.67	\$160.61	\$203.07	\$184.61
F	\$241.84	\$219.86	\$277.99	\$252.72
G	\$218.03	\$198.21	\$250.61	\$227.83
N	\$182.46	\$165.88	\$209.72	\$190.66

## Age 78

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$180.79	\$164.36	\$207.81	\$188.92
F	\$248.91	\$226.29	\$286.12	\$260.11
G	\$225.17	\$204.70	\$258.81	\$235.29
N	\$188.62	\$171.48	\$216.82	\$197.11

## Age 79

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$184.23	\$167.49	\$211.76	\$192.51
F	\$255.99	\$232.72	\$294.25	\$267.50
G	\$231.51	\$210.47	\$266.11	\$241.92
N	\$194.79	\$177.09	\$223.91	\$203.56

## Age 80

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$189.32	\$172.11	\$217.61	\$197.83
F	\$262.72	\$238.84	\$301.98	\$274.53
G	\$237.94	\$216.31	\$273.50	\$248.64
N	\$200.22	\$182.02	\$230.13	\$209.21

## Age 81

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$194.30	\$176.64	\$223.33	\$203.03
F	\$269.29	\$244.81	\$309.52	\$281.39
G	\$244.22	\$222.02	\$280.72	\$255.20
N	\$205.50	\$186.82	\$236.21	\$214.74

## Age 82

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$199.15	\$181.05	\$228.92	\$208.11
F	\$275.70	\$250.64	\$316.89	\$288.09
G	\$250.34	\$227.59	\$287.74	\$261.59
N	\$210.66	\$191.51	\$242.14	\$220.13



## Age 83

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$203.89	\$185.36	\$234.36	\$213.06
F	\$281.94	\$256.31	\$324.07	\$294.61
G	\$256.33	\$233.03	\$294.63	\$267.85
N	\$215.68	\$196.08	\$247.90	\$225.37

## Age 84

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$208.52	\$189.57	\$239.67	\$217.89
F	\$288.02	\$261.84	\$331.06	\$300.97
G	\$262.14	\$238.31	\$301.31	\$273.92
N	\$220.58	\$200.53	\$253.55	\$230.50

## Age 85

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$213.01	\$193.65	\$244.84	\$222.59
F	\$293.95	\$267.23	\$337.87	\$307.16
G	\$267.80	\$243.46	\$307.82	\$279.84
N	\$225.35	\$204.87	\$259.02	\$235.48

## Age 86

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$217.40	\$197.64	\$249.88	\$227.17
F	\$299.71	\$272.47	\$344.49	\$313.18
G	\$273.31	\$248.47	\$314.16	\$285.60
N	\$229.98	\$209.08	\$264.35	\$240.32

## Age 87

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$221.66	\$201.51	\$254.78	\$231.62
F	\$305.32	\$277.57	\$350.94	\$319.04
G	\$278.68	\$253.35	\$320.33	\$291.21
N	\$234.50	\$213.19	\$269.54	\$245.04

## Age 88

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$225.80	\$205.28	\$259.55	\$235.96
F	\$310.76	\$282.51	\$357.19	\$324.72
G	\$283.88	\$258.08	\$326.31	\$296.65
N	\$238.88	\$217.17	\$274.58	\$249.62

## Age 89

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$229.84	\$208.95	\$264.18	\$240.17
F	\$316.05	\$287.32	\$363.28	\$330.26
G	\$288.93	\$262.67	\$332.11	\$301.92
N	\$243.13	\$221.03	\$279.46	\$254.06

## Age 90

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$233.73	\$212.49	\$268.66	\$244.24
F	\$321.17	\$291.98	\$369.17	\$335.61
G	\$293.85	\$267.14	\$337.76	\$307.06
N	\$247.25	\$224.78	\$284.20	\$258.37

## Age 91

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$237.53	\$215.94	\$273.02	\$248.20
F	\$326.13	\$296.49	\$374.86	\$340.79
G	\$298.59	\$271.45	\$343.21	\$312.01
N	\$251.26	\$228.42	\$288.80	\$262.55

## Age 92

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$241.19	\$219.27	\$277.24	\$252.04
F	\$330.94	\$300.86	\$380.40	\$345.82
G	\$303.18	\$275.62	\$348.49	\$316.81
N	\$255.12	\$231.93	\$293.23	\$266.58

## Age 93

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$244.76	\$222.51	\$281.32	\$255.75
F	\$335.58	\$305.08	\$385.72	\$350.66
G	\$307.62	\$279.66	\$353.59	\$321.45
N	\$258.86	\$235.33	\$297.53	\$270.49

## Age 94

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$248.18	\$225.62	\$285.26	\$259.33
F	\$340.06	\$309.15	\$390.87	\$355.34
G	\$311.91	\$283.56	\$358.52	\$325.93
N	\$262.47	\$238.61	\$301.69	\$274.27

## Age 95

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$251.50	\$228.64	\$289.08	\$262.80
F	\$344.38	\$313.08	\$395.85	\$359.87
G	\$316.05	\$287.32	\$363.27	\$330.25
N	\$265.93	\$241.76	\$305.67	\$277.89

## Age 96

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$254.70	\$231.55	\$292.76	\$266.15
F	\$348.54	\$316.86	\$400.63	\$364.21
G	\$320.03	\$290.94	\$367.85	\$334.41
N	\$269.29	\$244.81	\$309.54	\$281.40

## Age 97

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$257.78	\$234.35	\$296.30	\$269.37
F	\$352.56	\$320.51	\$405.24	\$368.40
G	\$323.85	\$294.41	\$372.25	\$338.41
N	\$272.51	\$247.74	\$313.23	\$284.76

## Age 98

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$260.74	\$237.04	\$299.70	\$272.46
F	\$356.38	\$323.99	\$409.65	\$372.41
G	\$327.52	\$297.75	\$376.47	\$342.25
N	\$275.60	\$250.55	\$316.78	\$287.99

## Age 99

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$263.58	\$239.62	\$302.96	\$275.42
F	\$360.08	\$327.35	\$413.88	\$376.26
G	\$331.05	\$300.96	\$380.52	\$345.93
N	\$278.57	\$253.25	\$320.19	\$291.09

## Age 100 +

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$266.29	\$242.09	\$306.09	\$278.27
F	\$363.59	\$330.54	\$417.93	\$379.94
G	\$334.42	\$304.02	\$384.39	\$349.45
N	\$281.40	\$255.82	\$323.45	\$294.05

You have the option to purchase any of the Medicare Supplement benefit plans shown on the front cover in white as Standard Plans.

## **PREMIUM INFORMATION**

Blue Cross and Blue Shield of Illinois can only raise your premium if we raise the premium for all policies like yours in the state. We will not change your premium or cancel your policy because of poor health. Premiums change at age 65 and every year thereafter up to age 100. If your premium changes, you will be notified at least 30 days in advance.

### **Gender**

One factor that will determine your premium is your gender. When completing the application, you will need to make a gender selection.

### **Tobacco User**

A Tobacco User is a person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco) occurring on average of four or more times per week that last occurred within the past six months. Tobacco products include but are not limited to: cigarettes, cigars, smokeless tobacco products, electronic cigarettes, dissolvable tobacco products, and vaping.

If you meet the definition of a Tobacco User, you may pay a higher premium for your health coverage.

## **PREMIUM DISCOUNTS**

BCBSIL Medicare Supplement premium discounts may be available. Eligibility criteria are described below. If you are eligible for a discount, the discount will be applied to your next bill and remain in effect as long as you are enrolled in your BCBSIL Medicare Supplement plan.

Discounts cannot be combined; only one type of discount per member permitted. The percentage discount is the same for each type of discount.

### **Household Discount**

You may be eligible for a discount if you and at least one or more other persons reside in the same household and both of you are enrolled in a BCBSIL Medicare Supplement policy. Applies to BCBSIL Medicare Supplement policies issued with an effective date on or after May 1, 2019.

### **Continue with Blue Discount**

You may be eligible for a discount if you were enrolled in commercial group or individual coverage with a Blue Cross and Blue Shield Plan issued in Illinois, Montana, New Mexico, Oklahoma, or Texas and that coverage was within one year of your BCBSIL Medicare Supplement policy becoming effective. Applies to BCBSIL Medicare Supplement policies issued with an effective date on or after April 1, 2022.

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## DISCLOSURES

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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 YOUR POLICY

If you find that you are not satisfied with your policy, you may return it to **Blue Medicare Supplement c/o Member Services, P.O. Box 3388 Scranton, PA 18505**. 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 will 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 Illinois nor its agents are connected with Medicare. This Outline of Coverage does not give you 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 A Pays	You Pay
<b>Hospitalization</b> <sup>5</sup> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,556	\$0	\$1,556 (Part A deductible)
61st through 90th day	All but \$389 a day	\$389 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$778 a day	\$778 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 <sup>6</sup>
Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care</b> <sup>5</sup> 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 \$194.50 a day	\$0	Up to \$194.50 a day
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

<sup>5</sup> A benefit period begins on the first day you receive services 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.

<sup>6</sup> NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

# Plan A

## MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

Services	Medicare Pays	Plan A Pays	You Pay
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$233 of Medicare-approved amounts <sup>7</sup>	\$0	\$0	\$233 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$233 of Medicare-approved amounts <sup>7</sup>	\$0	\$0	\$233 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services — Tests for Diagnostic Services</b>	100%	\$0	\$0

## MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan A Pays	You Pay
<b>Home Health Care Medicare-approved Services</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$233 of Medicare-approved amounts <sup>7</sup>	\$0	\$0	\$233 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

<sup>7</sup> Once you have been billed \$233 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

# Plan F

## MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

Services	Medicare Pays	Plan F Pays	You Pay
<b>Hospitalization</b> <sup>5</sup> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,556	\$1,556 (Part A deductible) <sup>2</sup>	\$0
61st through 90th day	All but \$389 a day	\$389 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$778 a day	\$778 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 <sup>6</sup>
Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care</b> <sup>5</sup> 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 \$194.50 a day	Up to \$194.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

# Plan F

## MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

Services	Medicare Pays	Plan F Pays	You Pay
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$233 of Medicare-approved amounts <sup>7</sup>	\$0	\$233 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$233 of Medicare-approved amounts <sup>7</sup>	\$0	\$233 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services — Tests for Diagnostic Services</b>	100%	\$0	\$0

## MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan F Pays	You Pay
<b>Home Health Care Medicare-approved Services</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$233 of Medicare-approved amounts <sup>7</sup>	\$0	\$233 (Part B deductible)	\$0
– Remainder of Medicare-approved amounts	80%	20%	\$0

## OTHER BENEFITS - NOT COVERED BY MEDICARE

<b>Foreign Travel — Not Covered by Medicare</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

# Plan G

## MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

Services	Medicare Pays	Plan G Pays	You Pay
<b>Hospitalization</b> <sup>5</sup> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,556	\$1,556 (Part A deductible) <sup>2</sup>	\$0
61st through 90th day	All but \$389 a day	\$389 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$778 a day	\$778 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 <sup>6</sup>
Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care</b> <sup>5</sup> 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 \$194.50 a day	Up to \$194.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

# Plan G

## MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

Services	Medicare Pays	Plan G Pays	You Pay
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$233 of Medicare-approved amounts <sup>7</sup>	\$0	\$0	\$233 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$233 of Medicare-approved amounts <sup>7</sup>	\$0	\$0	\$233 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services — Tests for Diagnostic Services</b>	100%	\$0	\$0
<b>MEDICARE (PARTS A &amp; B)</b>			
Services	Medicare Pays	Plan G Pays	You Pay
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$233 of Medicare-approved amounts <sup>7</sup>	\$0	\$0	\$233 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0
<b>OTHER BENEFITS – NOT COVERED BY MEDICARE</b>			
<b>Foreign Travel — Not Covered by Medicare</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

# Plan N

## MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

Services	Medicare Pays	Plan N Pays	You Pay
<b>Hospitalization</b> <sup>5</sup> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,556	\$1,556 (Part A deductible) <sup>2</sup>	\$0
61st through 90th day	All but \$389 a day	\$389 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$778 a day	\$778 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 <sup>6</sup>
Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care</b> <sup>5</sup> 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 \$194.50 a day	Up to \$194.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

# Plan N

## MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

Services	Medicare Pays	Plan N Pays	You Pay
<b>Medical Expenses — In or Out of the Hospital And Outpatient Hospital Treatment</b> , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$233 of Medicare-approved amounts <sup>7</sup>	\$0	\$0	\$233 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$233 of Medicare-approved amounts <sup>7</sup>	\$0	\$0	\$233 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services — Tests for Diagnostic Services</b>	100%	\$0	\$0
<b>MEDICARE (PARTS A &amp; B)</b>			
Services	Medicare Pays	Plan N Pays	You Pay
<b>Home Health Care Medicare-approved Services</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$233 of Medicare-approved amounts <sup>7</sup>	\$0	\$0	\$233 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0



# Plan N

## OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan N Pays	You Pay
<b>Foreign Travel — Not Covered by Medicare</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

### Important Information about Quotes for Medicare Supplement

Quoted prices are based on the criteria specified during your search. This illustration is subject to Blue Cross and Blue Shield of Illinois's rating or underwriting and approval, as appropriate, and does not guarantee rates, coverage or effective date. Furthermore, rates are subject to change if any of the information you have provided changes when and if a policy is approved. In addition, Blue Cross and Blue Shield of Illinois reserves the right to change rates from time to time. Not connected with or endorsed by the U.S. Government or Federal Medicare Program.

Medicare Supplement insurance plans are offered by Blue Cross and Blue Shield of Illinois, which refers to HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association.



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# Application for Medicare Supplement Insurance Plan

## Instructions

- To be considered for coverage, you must have Medicare Parts A and B, reside in Illinois, and be:
  - age 65 or over or
  - applying within 6 months of your Medicare Part B effective date.
- If submitting a paper application, please complete in ink. Be sure to sign and date on the appropriate line(s) on pages 6, 7 and 11. Send no money now! No payment is due until you have a chance to review your policy and make sure the coverage is right for you.

**Plan Selection** Check one box to apply for a Medicare Supplement Insurance Plan.

Plan A Secure     
  Plan F Secure     
  Plan G Secure     
  Plan N Secure

**Requested Policy Effective Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Note: Plan F Secure is only available if you are Medicare-eligible prior to 2020.

**Applicant Information**

Name (First)		(Middle)	(Last)	
Home Address (No P.O. Boxes)		City	State <b>IL</b>	ZIP
Correspondence / Billing Address		City	State	ZIP
Primary Phone		Secondary Phone	Age	Date of Birth / /
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number		Email Address	
Preferred Method of Contact: <input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> Email				

**Tobacco Use**

Blue Cross and Blue Shield of Illinois (BCBSIL) defines a tobacco user as a person who is using or has used any tobacco products in the last 6 months prior to the date of enrollment for a plan. This includes but is not limited to cigarettes, cigars, smokeless tobacco products, electronic cigarettes, dissolvable tobacco products, and vaping.

Within the past 6 months, have you used tobacco 4 or more times per week on average, excluding religious or ceremonial uses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Applicant Name: \_\_\_\_\_

### Premium Discounts

BCBSIL Medicare Supplement premium discounts may be available. See below for details. If you are eligible for a discount, the discount will be applied to your next bill and remain in effect as long as you are enrolled in your BCBSIL Medicare Supplement plan.

Discounts cannot be combined; only one type of discount per member permitted. The percentage discount is the same for each type of discount.

### Household Discount

You may be eligible if you and at least one or more other persons reside in the same household and both of you are enrolled in a BCBSIL Medicare Supplement policy. Applies to BCBSIL Medicare Supplement policies issued with an effective date on or after May 1, 2019.

Are you applying for this discount?

Yes

No

**If yes**, provide a qualifying household member's information:

Name (First)

(Last)

Subscriber/Enrollee ID

### Continue with Blue Discount

You may be eligible if you had commercial group or individual health insurance coverage with a Blue Cross and Blue Shield Plan issued in Illinois, Montana, New Mexico, Oklahoma or Texas and that coverage was within one year of your BCBSIL Medicare Supplement policy becoming effective. Applies to BCBSIL Medicare Supplement policies issued with an effective date on or after April 1, 2022.

Are you applying for this discount?

Yes

No

**If yes**, provide your previous commercial group or individual coverage subscriber ID:

Applicant Name: \_\_\_\_\_

**Payment Option** (Select one payment option)

1. Premium **deducted from bank account** (choose one):  **Checking**       **Savings**

Account holder name:

Bank name:

Bank routing number:      Bank account number:

Account Owner Signature (if different than applicant)

**Bank Draft Authorization Agreement**  
By signing this application, I request and authorize BCBSIL and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the financial institution named below to accept and honor the same to my account.  
I understand that this request for coverage is not an employer group health plan and is not intended, in any way, to be an employer sponsored health insurance plan. I certify the employer(s) of those applying for coverage will not contribute any part of the premium or provide reimbursement for any part of the premium now or in the future.  
I also understand that both the financial institution and BCBSIL reserve the right to terminate this payment program and/or my participation therein. To make changes to my financial institution I understand that I will need to provide at least 10 days advanced notice to BCBSIL by telephone prior to a scheduled withdrawal date. I authorize BCBSIL to deduct the premium payments from my checking or savings account. If the draft date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day.

2.  Premium **to be billed by mail**

3. I will pay my premium:  **Monthly**     **Quarterly**     **Semi-Annually**     **Annually**

**Medicare Beneficiary Identifier**

**Please copy the Medicare Beneficiary Identifier from your red, white and blue Medicare Card. This number must be provided to us to complete your application process.**

Medicare Beneficiary Identifier

Part A Effective Date:      /      /      /      /      /      /      /      /      /      /  
Part B Effective Date:      /      /      /      /      /      /      /      /      /      /

Applicant Name: \_\_\_\_\_

<b>Consumer Protection Information</b>		
If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement Insurance Plans. <b>Please include a copy of the notice from your prior insurer with your application.</b>		
<b>Please answer all questions. Please mark Yes or No below with an "X" to the best of your knowledge.</b>		
1. Did you turn age 65 in the last 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Did you enroll in Medicare Part B in the last 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>If yes</b> , what is the effective date?	Effective Date:	
3. Are you covered for medical assistance through the state Medicaid program? <b>NOTE TO APPLICANT:</b> <i>If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>a. If yes</b> , will Medicaid pay your premiums for this Medicare Supplement policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>b. If yes</b> , do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates. <i>(If you are still covered under this plan, leave "End Date" blank.)</i>	Start Date:	End Date:
<b>a.</b> If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>b.</b> Was this your first time in this type of Medicare plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>c.</b> Did you drop a Medicare Advantage policy to enroll in the Medicare plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Do you have another Medicare Supplement policy in force?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>a. If so</b> , with what company, and what plan do you have? _____		
<b>b. If so</b> , do you intend to replace your current Medicare Supplement policy with this policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you had coverage under any other health insurance within the past 63 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>a. If so</b> , with what company, and what kind of policy? <i>(For example, an employer, union, or individual plan)</i> _____		
<b>b.</b> What are your dates of coverage under the other policy? <i>(If you are still covered under the other policy, leave "End Date" blank.)</i>	Start Date:	End Date:

## Statements

1. You do not need more than one Medicare Supplement policy.
  2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.
  3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
  4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility.\*
  5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan.\*
  6. Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance Plan and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).  
For information on Medicaid eligibility, call your local Social Security office. For questions on Medicare Supplement Insurance Plans, call 1-800-MEDICARE (1-800-633-4227).
  7. Under Illinois Senate Bill 147, if you are between the ages of 65 and 75 and have enrolled in a Medicare Supplement policy, you are entitled to an annual open enrollment period lasting 45 days starting with your birthday. During this time, you will be able to purchase a BCBSIL Medicare Supplement policy that offers benefits equal to or lesser than those provided by your previous coverage. This policy cannot be denied or conditioned, nor discriminate in the pricing of coverage because of health status, claims experience, receipt of health care, or a medical condition of the individual. Purchasing a new Medicare Supplement policy will require reapplying within the 45 day window.
- \* If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

## Questions?

Call us at our Customer Service toll-free number **877-384-9297**,  
call your insurance agent at the number listed on page 7, or visit **[www.bcbsil.com](http://www.bcbsil.com)**.

## Proxy Statement

The undersigned hereby appoints the Board of Directors of HCSC Insurance Services Company, a Mutual Legal Reserve Company, or any successor thereof ("HISC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HISC (and at all meetings of members of any successor of HISC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters (300 E Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

Applicant Signature (optional):

Print Your Name as You Signed It:

Date:

/ /

Applicant Name: \_\_\_\_\_

### Acknowledgements and Signature

1. I hereby apply for coverage and request a policy to review for the Medicare Supplement policy indicated.
2. I understand that once my first premium payment is received, I will be covered as of the date shown on the Company identification card. Once coverage begins, I understand I have 30 days to return my policy materials and receive a full refund for any premiums paid. Services are covered only when received on or after the effective date of the policy chosen, except in the case of inpatient services, where the admission must occur on or after the effective date to be covered.
3. I hereby declare that the statements and answers on this application, including but not limited to those relating to age and medical history, are true and complete to the best of my knowledge and belief. I agree that the Company, believing them to be true, shall rely and act upon them accordingly. I hereby agree to furnish any additional information, if requested.
4. I understand that the Company has the right to reject my application. If the Company rejects my application, I will be notified in writing. If this application is accepted, it will become part of the insurance policy.
5. I acknowledge that I have read and understand the Statements section regarding Medicare Supplement coverage. If eligible for a Medicare Select Plan, I have also read and understand the statements regarding Medicare Select as described in the Outline of Coverage. **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of a felony.
6. I acknowledge that any agent is acting on my behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an individual policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such individual policy.
7. I acknowledge if I desire additional information regarding any commissions or other compensation paid to the agent by the Company in connection with the issuance of the individual policy, I should contact the agent.
8. I acknowledge that I have received a copy of the Medicare Supplement Buyer's Guide.
9.  **Outline of Coverage:** I acknowledge receipt of Outline of Coverage.

### Signature Required

Must be signed **in ink** and dated to avoid processing delays. For Power of Attorney and Legal Guardianships, be sure to submit copies of the court documents with the application.

Applicant:	Date: / /
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### Agent Information (If Applicable)

*The following information is to be filled out by an agent, if Applicant is purchasing coverage through an agent.*

Please list any other health insurance policies or coverages sold to the applicant which are still in force:

Please list any other health insurance policies or coverages sold to the applicant within the last five (5) years which are no longer in force:

I have reaffirmed that the information supplied on this application is accurate and complete.

Agent Signature:	Date: / /
Print Name:	Broker Code:
Agency Name (If Applicable):	Agent Phone:



**PLEASE CONTINUE ON THIS PAGE IF YOU ARE NOT NEWLY  
ELIGIBLE TO ENROLL IN MEDICARE DUE TO AGE OR DISABILITY.**

**Guaranteed Issue Eligibility**

Please mark Yes or No to questions 1–8 with an “X.” If you answer “Yes” to any and if you are applying before the 63rd day after your coverage terminated, you are eligible for guaranteed issuance of this Medicare Supplement policy. If you are eligible for guaranteed issuance of this policy, do not complete the Health History/Medical Questions that start on page 10. Proceed to page 11 and sign the Medical Authorization.

**Have any of the following events listed below, and on the next page, occurred?**

<p><b>1.</b> The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>2.</b> The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual’s enrollment with such provider if such individual was enrolled in a Medicare Advantage plan: <b>(A)</b> the certification of the organization or plan has been terminated; or <b>(B)</b> the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; <b>(C)</b> the individual is no longer eligible to elect the plan because of a change in the individual’s place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual’s enrollment on the basis described in section 1851 (g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area; <b>(D)</b> the individual demonstrates, in accordance with guidelines established by the Secretary, that: (i) the organization offering the plan substantially violated a material provision of the organization’s contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or (ii) the organization, or agent or other entity acting on the organization’s behalf, materially misrepresented the plan’s provisions in marketing the plan to the individual; or <b>(E)</b> the individual meets such other exceptional conditions as the Secretary may provide.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Guaranteed Issue Eligibility</b>		
<p><b>3.</b> The individual is enrolled with an entity listed in subparagraphs (A)-(D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) of this subsection: <b>(A)</b> an eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost); <b>(B)</b> a similar organization operating under demonstration project authority, effective for periods before April 1, 1999; <b>(C)</b> an organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or <b>(D)</b> an organization under a Medicare Select policy; and</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>4.</b> The individual is enrolled under a Medicare Supplement policy and the enrollment ceases because: <b>(A)</b> of the insolvency of the issuer or bankruptcy of the nonissuer organization; or of other involuntary termination of coverage or enrollment under the policy; <b>(B)</b> the issuer of the policy substantially violated a material provision of the policy; or <b>(C)</b> the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>5.</b> The individual was enrolled under a Medicare Supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under section 1851 (e) of the Social Security Act); or</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>6.</b> The individual, upon first becoming enrolled in Medicare part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan no later than 12 months after the effective date of enrollment.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>7.</b> The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare Supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (c)(4) of this section.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p><b>8.</b> The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## Health History / Medical Questions



**Note:** If you are eligible for Guaranteed Issue or in your Open Enrollment period, you are not required to answer the following health questions. (Continue to page 11.)

**Please answer the following health history questions.**

1. What is your height?	Ft.	In.
2. What is your weight?	Lbs.	
3. When you first became eligible for Medicare, was it either because of disability or end stage renal disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Within the past 3 years, have you been diagnosed, treated, hospitalized or recommended for treatment, including drug therapy, by a physician or any other provider for any of the following:		
a. Diabetes with amputation, loss of sight or complications affecting the kidney?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Organ or tissue transplant (except cornea)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Cancer (excluding basal cell or squamous cell cancer of the skin)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Leukemia or Hodgkin's disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Stroke, Transient Ischemic Attack (TIA), or mini-stroke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. Alzheimer's disease, senility, dementia or brain disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g. Parkinson's disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h. Carotid artery disease, heart attack, or heart by-pass surgery or angioplasty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i. Congestive heart failure or heart valve replacement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
j. Nephritis or kidney failure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
k. Cirrhosis of the liver or Hepatitis C?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
l. Multiple Sclerosis or neuromuscular disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
m. Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
n. Respiratory or lung disease requiring use of oxygen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
o. Alcohol or chemical dependency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Within the past 3 years, have you been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or human immunodeficiency virus (HIV) infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Within the past 2 years, have you been advised to have kidney dialysis, joint replacement, or surgery for the heart, arteries or intestines that has not yet been done?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Within the past 2 years, have you been hospitalized 2 or more times, or have you been confined to a nursing home or other care facility for 14 or more days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Applicant Name: \_\_\_\_\_

<b>Health History / Medical Questions</b>		
<b>8.</b> Are you currently confined, or has confinement been recommended within the next 6 months to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a wheelchair or a home health care agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>9.</b> Do you need or receive help from any other person to perform any of the activities below because of health or physical difficulty? <ul style="list-style-type: none"><li>• Taking Medications</li><li>• Eating</li><li>• Walking</li><li>• Bathing</li><li>• Dressing</li><li>• Toileting</li><li>• Moving from place to place in your home</li><li>• Getting in and out of bed or chairs</li></ul>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Medical Authorization</b>
<p>I authorize any medical professional, hospital, clinic or other medical or medically related facility, governmental agency or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me, including and without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information.</p> <p>I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and shall remain valid for 24 months, unless revoked by me in writing, which I may do at any time by sending a written request to the Company. Any revocation will not affect the activities of the Company prior to receipt of the revocation.</p>

<b>SIGNATURE REQUIRED</b>	
<i>Must be signed <b>in ink</b> and dated to avoid processing delays.</i>	
Applicant: _____	Date:        /        /

## Questions?

Call us at our Customer Service toll-free number **877-587-6616**, call your insurance agent at the number listed on page 7, or visit **www.bcbsil.com**.

Applicant Name: \_\_\_\_\_

## Checklist

- Have you signed on pages 6, 7, and 11?
- If you're working with an agent, has the agent signed on page 7 (if applicable)?
- Have you answered all Health History / Medical Questions on pages 10–11?
- Have you made sure your requested effective date on page 1 is the 1st through the 28th of the month?

### **Return to your agent or mail this application to:**

Blue Medicare Supplement

c/o Member Services

PO Box 3388

Scranton, PA 18505

Medicare Supplement insurance plans are offered by Blue Cross and Blue Shield of Illinois, which refers to HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association.



Applicant's Name \_\_\_\_\_

Policy Number \_\_\_\_\_

Name of Existing Insurer \_\_\_\_\_ Expiration Date of Existing Insurance \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Service	Benefit	Medicare Pays	Existing Coverage Pays	Supplement Covers	You Pay
<b>Hospital Inpatient Services</b>	Days 1-60	All but \$1,556		<input type="checkbox"/> \$1,556 Part A Deductible* <b>or</b> <input type="checkbox"/> \$0 Plan A Only	<input type="checkbox"/> \$0 <b>or</b> <input type="checkbox"/> \$1,556 Part A Deductible
	Days 61-90	All but \$389 a day		\$389 a day	\$0
	Days 91-150 (Lifetime Reserve)	All but \$778 a day		\$778 a day	\$0
	After Day 150	\$0		All Medicare-approved amounts for an additional 365 days	\$0
<b>Skilled Nursing Home Care</b>	Days 1-20	All costs		\$0	\$0
	Days 21-100	All but \$194.50 a day		<input type="checkbox"/> \$194.50 a day <b>or</b> <input type="checkbox"/> \$0 Plan A only	<input type="checkbox"/> \$0 <b>or</b> <input type="checkbox"/> \$194.50 a day
	After Day 100	\$0		\$0	All costs
<b>Medical Expenses</b>	Physician's Services in hospital, office, or home; inpatient and outpatient medical services and supplies at a hospital; physical and speech therapy; and ambulance	80% of the Medicare-determined allowable charges after a \$233 deductible per calendar year		<input type="checkbox"/> After \$233 Medicare Part B Deductible, 20% of Medicare-approved amounts for Plans A, F, High F, G, G Plus and High G <input type="checkbox"/> After \$233 Medicare Part B Deductible, Plan N pays the balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. <input type="checkbox"/> \$233 Part B deductible for Plans F and High F <input type="checkbox"/> 100% Part B Excess Charges for Plans F, High F, G, G Plus and High G	Charges not covered by policy and Medicare  <input type="checkbox"/> \$233 Part B deductible for Plans A, G, G Plus, High G and N <input type="checkbox"/> Part B Excess Charges for Plans A and N

This policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Signature of Applicant X** \_\_\_\_\_

**Signature of Producer X** \_\_\_\_\_

**WHITE: RETURN WITH APPLICATION • YELLOW: FOR CLIENT'S RECORDS**

Not connected with or endorsed by the U.S. Government or Federal Medicare Program.

Medicare Supplement plans provided by Blue Cross and Blue Shield of Illinois, which refers to Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), and refers to HCSC Insurance Services Company (HISC). HCSC and HISC are independent licensees of the Blue Cross and Blue Shield Association.



## Notice to Applicant Regarding REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

### Save this notice! It may be important to you in the future

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage coverage and replace it with a policy to be issued by Blue Cross and Blue Shield of Illinois. Your new policy will provide 30 days within which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

### Statement to Applicant by Blue Cross and Blue Shield of Illinois:

I have reviewed your current medical or health coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reasons:

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment:

Other (please specify): \_\_\_\_\_

### Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

\_\_\_\_\_  
AGENT'S SIGNATURE

\_\_\_\_\_  
PRINTED NAME OF APPLICANT

\_\_\_\_\_  
PRINTED NAME OF AGENT

\_\_\_\_\_  
APPLICANT'S SIGNATURE

\_\_\_\_\_  
AGENT'S WRITING ID NUMBER

\_\_\_\_\_  
DATE

Not connected with or endorsed by the U.S. Government or Federal Medicare Program.

Medicare Supplement Insurance Plans have eligibility requirements, exclusions and limitations. For costs and complete details (including outlines of coverage), call a licensed insurance agent at the toll-free number shown.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

HMO, HMO-POS and PPO plans provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in HCSC's plans depends on contract renewal.