BlueCross BlueShield of Illinois

Underwritten by HCSC Insurance Services Company

Home Office Use Only

Application for Medicare Supplement Insurance Plan

Instructions

1. To be considered for coverage, you must have Medicare Parts A and B, reside in Illinois, and be: a) age 65 or over or b) applying within 6 months of your Medicare Part B effective date.
2. **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 12.** 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 F Plus Secure**
- **Plan G Secure**
  - ☐ Standard
  - ☐ Medicare Select
- **Plan G Plus Secure**
  - ☐ Standard
  - ☐ Medicare Select
- ☐ **Plan N Secure**
- ☐ **Plan N Plus 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 **IL**	ZIP
Correspondence / Billing Address	City	State	ZIP
Primary Phone	Secondary Phone	Age	Date of Birth / /
Gender ☐ Male ☐ Female	Social Security Number	Email Address	
Preferred Method of Contact: ☐ Mail ☐ Phone ☐ 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?	☐ Yes	☐ No

Applicant Name: _____

Premium Discounts

A BCBSIL Medicare Supplement premium discount 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 is permitted.

Household Discount

You may be eligible for a discount if you reside with a spouse or civil union/domestic partner or have resided with as many as three adults age 60 or older for the last 12 months. Applies to BCBSIL Medicare Supplement policies issued with an effective date on or after May 1, 2019. The discount is 10%.

Are you applying for this discount?	☐ Yes	☐ No

Continue with Blue℠ Discount

You may be eligible for a discount if you enrolled in a BCBSIL Medicare Supplement policy issued with an effective date on or after April 1, 2022 and you were enrolled in a Blue Cross and Blue Shield commercial group or individual health insurance coverage plan and that coverage was within one year of your BCBSIL Medicare Supplement policy becoming effective. The discount is 7%.

Are you applying for this discount?	☐ Yes	☐ No
If yes, provide your previous commercial group or individual coverage subscriber ID:		

Blue Family Discount℠

You may be eligible for a discount if you enrolled in a BCBSIL Medicare Supplement policy issued with an effective date on or after April 1, 2024 and you meet the criteria for both the Household Discount AND the Continue with Blue Discount. The discount is 12%.

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: _____

Consumer Protection Information

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. **Please include a copy of the notice from your prior insurer with your application.**

Please answer all questions. Please mark Yes or No below with an "X" to the best of your knowledge.

1. Did you turn age 65 in the last 6 months?	☐ Yes	☐ No
2. Did you enroll in Medicare Part B in the last 6 months?	☐ Yes	☐ No
If yes, what is the effective date?	Effective Date:	
3. Are you covered for medical assistance through the state Medicaid program? **NOTE TO APPLICANT:** *If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.*	☐ Yes	☐ No
a. If yes, will Medicaid pay your premiums for this Medicare Supplement policy?	☐ Yes	☐ No
b. If yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	☐ Yes	☐ 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. *(If you are still covered under this plan, leave "End Date" blank.)*	Start Date:	End Date:
a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	☐ Yes	☐ No
b. Was this your first time in this type of Medicare plan?	☐ Yes	☐ No
c. Did you drop a Medicare Advantage policy to enroll in the Medicare plan?	☐ Yes	☐ No
5. Do you have another Medicare Supplement policy in force?	☐ Yes	☐ No
a. If so, with what company, and what plan do you have? _____		
b. If so, do you intend to replace your current Medicare Supplement policy with this policy?	☐ Yes	☐ No
6. Have you had coverage under any other health insurance within the past 63 days?	☐ Yes	☐ No
a. If so, with what company, and what kind of policy? *(For example, an employer, union, or individual plan)* _____		
b. What are your dates of coverage under the other policy? *(If you are still covered under the other policy, leave "End Date" blank.)*	Start Date:	End Date:

Applicant Name: _____

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 reinstituted 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 reinstituted 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 reinstituted 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 8, or visit **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: / /

Applicant Name: _____

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:

Applicant Name: _____

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 11. Proceed to page 12 and sign the Medical Authorization.

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

1. 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.	☐ Yes	☐ No
2. 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: **(A)** the certification of the organization or plan has been terminated; or **(B)** the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; **(C)** 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; **(D)** 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 **(E)** the individual meets such other exceptional conditions as the Secretary may provide.	☐ Yes	☐ No

Applicant Name: _____

Guaranteed Issue Eligibility		
3. 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: **(A)** an eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost); **(B)** a similar organization operating under demonstration project authority, effective for periods before April 1, 1999; **(C)** an organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or **(D)** an organization under a Medicare Select policy; and	☐ Yes	☐ No
4. The individual is enrolled under a Medicare Supplement policy and the enrollment ceases because: **(A)** 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)** the issuer of the policy substantially violated a material provision of the policy; or **(C)** 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;	☐ Yes	☐ No
5. 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	☐ Yes	☐ No
6. 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.	☐ Yes	☐ No
7. 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.	☐ Yes	☐ No
8. The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).	☐ Yes	☐ No

Applicant Name: _____

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 12.)

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?	☐ Yes	☐ 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?	☐ Yes	☐ No
b. Organ or tissue transplant (except cornea)?	☐ Yes	☐ No
c. Cancer (excluding basal cell or squamous cell cancer of the skin)?	☐ Yes	☐ No
d. Leukemia or Hodgkin's disease?	☐ Yes	☐ No
e. Stroke, Transient Ischemic Attack (TIA), or mini-stroke?	☐ Yes	☐ No
f. Alzheimer's disease, senility, dementia or brain disorder?	☐ Yes	☐ No
g. Parkinson's disease?	☐ Yes	☐ No
h. Carotid artery disease, heart attack, or heart by-pass surgery or angioplasty?	☐ Yes	☐ No
i. Congestive heart failure or heart valve replacement?	☐ Yes	☐ No
j. Nephritis or kidney failure?	☐ Yes	☐ No
k. Cirrhosis of the liver or Hepatitis C?	☐ Yes	☐ No
l. Multiple Sclerosis or neuromuscular disorders?	☐ Yes	☐ No
m. Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease)?	☐ Yes	☐ No
n. Respiratory or lung disease requiring use of oxygen?	☐ Yes	☐ No
o. Alcohol or chemical dependency?	☐ Yes	☐ 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?	☐ Yes	☐ 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?	☐ Yes	☐ 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?	☐ Yes	☐ No

Applicant Name: _____

Health History / Medical Questions		
8. 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?	☐ Yes	☐ No
9. Do you need or receive help from any other person to perform any of the activities below because of health or physical difficulty? • Taking Medications • Eating • Walking • Bathing • Dressing • Toileting • Moving from place to place in your home • Getting in and out of bed or chairs	☐ Yes	☐ No

Medical Authorization

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.

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.

SIGNATURE REQUIRED

*Must be signed **in ink** and dated to avoid processing delays.*

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 8, or visit **www.bcbsil.com**.

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 Name: _____

Checklist

- ☐ Have you signed on pages 6, 7, and 12?
- ☐ If you're working with an agent, has the agent signed on page 8 (if applicable)?
- ☐ Have you answered all Health History / Medical Questions on pages 11–12?
- ☐ 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

BlueCross BlueShield of Illinois

Medicare Supplement Policy Checklist

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
Hospital Inpatient Services	Days 1-60	All but $1,676		☐ $1,676 Part A Deductible* **or** ☐ $0 Plan A Only	☐ $0 **or** ☐ $1,676 Part A Deductible
	Days 61-90	All but $419 a day		$419 a day	$0
	Days 91-150 (Lifetime Reserve)	All but $838 a day		$838 a day	$0
	After Day 150	$0		All Medicare-approved amounts for an additional 365 days	$0
Skilled Nursing Home Care	Days 1-20	All costs		$0	$0
	Days 21-100	All but $209.50 a day		☐ $209.50 a day **or** ☐ $0 Plan A only	☐ $0 **or** ☐ $209.50 a day
	After Day 100	$0		$0	All costs
Medical Expenses	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 changes after a $257 deductible per calendar year		☐ After $257 Medicare Part B Deductible, 20% of Medicare-approved amounts for Plans A, F, High F, F Plus, G, G Plus, High G, and High G Plus ☐ After $257 Medicare Part B Deductible, Plans N and N Plus pays the balance, other than up to $20 per office visit and up to $50 per emergency room visit. ☐ $257 Part B deductible for Plans F, High F and F Plus ☐ 100% Part B Excess Charges for Plans F, High F, F Plus, G, G Plus, High G, and High G Plus	Charges not covered by policy and Medicare ☐ $257 Part B deductible for Plans A, G, G Plus, High G, High G Plus, N, and N Plus. ☐ Part B Excess Charges for Plans A, N, and N Plus

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.

BlueCross BlueShield of Illinois

Blue Medicare Supplement℠ • c/o Member Services
P.O. Box 3388 • Scranton, PA 18505

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.

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.

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.

IL-MS-NOR-2022 23648.0921

BlueCross BlueShield of Illinois

Underwritten by HCSC Insurance Services Company

Outline of Medicare Supplement Coverage — Standard Benefits for Plans A, F, F Plus, N, and N Plus; Standard and Medicare Select Benefits[4] for Plan G and Plan G Plus

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available. 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.

Note: A ✔ means 100% of the benefit is paid

Benefits	**Plans Available to All Applicants**								**Medicare first eligible before 2020 only**	
	A	**B**	**D**	**G[1]**	**K[2]**	**L[2]**	**M**	**N**	**C**	**F[1]**
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	copays apply[3]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit in 2025[2]					$7,220[2]	$3,610[2]				

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

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2,870 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible. NOTE: HISC currently does not offer these high deductible options.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

[4] Medicare Select Plans require that you use Blue Cross and Blue Shield of Illinois contracting Medicare Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the $1,676 deductible is covered at any hospital from which you receive care. Only certain hospitals are network providers under this policy. Check with your physician to determine if he or she has admitting privileges at the network hospital. If he or she does not, you may be required to use another physician at time of hospitalization or you will be required to pay for all expenses. If you move out of the service area or out of state for this Medicare Select Plan, there will be a reduction of benefit coverage and you will have the opportunity to purchase any Medicare Supplement policy with comparable or lesser benefits offered by the insurer, or Medicare Supplement/ Select plans A, B, C, D, F, G, K, or L from any insurer within 63 days of termination. (Note: Plans C and F are no longer available to people new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy Plan C or Plan F. People new to Medicare on or after January 1, 2020, have the right to buy Plans D and G instead of Plans C and F.)

Monthly Premium Rates effective April 1, 2025

Rates shown are for Illinois residents living outside Cook, DuPage, Kane, Lake, McHenry and Will Counties.

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

Age 65				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$138.87	$126.24	$159.63	$145.13
F	$189.91	$172.66	$218.31	$198.46
F Plus	$213.30	$196.05	$241.70	$221.85
G	$162.06	$147.34	$186.28	$169.36
G Plus	$185.45	$170.73	$209.67	$192.75
N	$118.79	$108.00	$136.54	$124.14
N Plus	$142.18	$131.39	$159.93	$147.53
G Select	$144.23	$131.13	$165.79	$150.73
G Select Plus	$167.62	$154.52	$189.18	$174.12

Age 66				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$138.87	$126.24	$159.63	$145.13
F	$189.91	$172.66	$218.31	$198.46
F Plus	$213.30	$196.05	$241.70	$221.85
G	$162.06	$147.34	$186.28	$169.36
G Plus	$185.45	$170.73	$209.67	$192.75
N	$118.79	$108.00	$136.54	$124.14
N Plus	$142.18	$131.39	$159.93	$147.53
G Select	$144.23	$131.13	$165.79	$150.73
G Select Plus	$167.62	$154.52	$189.18	$174.12

Age 67				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$138.87	$126.24	$159.63	$145.13
F	$189.91	$172.66	$218.31	$198.46
F Plus	$213.30	$196.05	$241.70	$221.85
G	$162.06	$147.34	$186.28	$169.36
G Plus	$185.45	$170.73	$209.67	$192.75
N	$118.79	$108.00	$136.54	$124.14
N Plus	$142.18	$131.39	$159.93	$147.53
G Select	$144.23	$131.13	$165.79	$150.73
G Select Plus	$167.62	$154.52	$189.18	$174.12

Age 68				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$146.23	$132.95	$168.08	$152.80
F	$197.48	$179.55	$226.99	$206.35
F Plus	$220.87	$202.94	$250.38	$229.74
G	$170.46	$154.96	$195.92	$178.11
G Plus	$193.85	$178.35	$219.31	$201.50
N	$125.20	$113.82	$143.91	$130.84
N Plus	$148.59	$137.21	$167.30	$154.23
G Select	$151.71	$137.91	$174.37	$158.52
G Select Plus	$175.10	$161.30	$197.76	$181.91

Age 69				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$154.40	$140.36	$177.48	$161.35
F	$206.74	$187.94	$237.63	$216.03
F Plus	$230.13	$211.33	$261.02	$239.42
G	$179.75	$163.42	$206.65	$187.86
G Plus	$203.14	$186.81	$230.04	$211.25
N	$132.51	$120.47	$152.32	$138.47
N Plus	$155.90	$143.86	$175.71	$161.86
G Select	$159.98	$145.44	$183.92	$167.20
G Select Plus	$183.37	$168.83	$207.31	$190.59

Age 70				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$162.57	$147.81	$186.86	$169.88
F	$216.81	$197.11	$249.21	$226.56
F Plus	$240.20	$220.50	$272.60	$249.95
G	$190.01	$172.75	$218.41	$198.55
G Plus	$213.40	$196.14	$241.80	$221.94
N	$139.81	$127.12	$160.71	$146.10
N Plus	$163.20	$150.51	$184.10	$169.49
G Select	$169.11	$153.75	$194.38	$176.71
G Select Plus	$192.50	$177.14	$217.77	$200.10

Age 71				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$170.73	$155.21	$196.24	$178.41
F	$227.73	$207.04	$261.76	$237.98
F Plus	$251.12	$230.43	$285.15	$261.37
G	$200.27	$182.06	$230.19	$209.26
G Plus	$223.66	$205.45	$253.58	$232.65
N	$147.13	$133.74	$169.12	$153.75
N Plus	$170.52	$157.13	$192.51	$177.14
G Select	$178.24	$162.03	$204.87	$186.24
G Select Plus	$201.63	$185.42	$228.26	$209.63

Age 72				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$178.10	$161.90	$204.71	$186.10
F	$238.67	$216.98	$274.33	$249.40
F Plus	$262.06	$240.37	$297.72	$272.79
G	$210.53	$191.38	$241.98	$219.97
G Plus	$233.92	$214.77	$265.37	$243.36
N	$154.42	$140.39	$177.51	$161.39
N Plus	$177.81	$163.78	$200.90	$184.78
G Select	$187.37	$170.33	$215.36	$195.77
G Select Plus	$210.76	$193.72	$238.75	$219.16

Age 73				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$185.43	$168.59	$213.14	$193.78
F	$248.75	$226.15	$285.91	$259.94
F Plus	$272.14	$249.54	$309.30	$283.33
G	$219.82	$199.84	$252.65	$229.70
G Plus	$243.21	$223.23	$276.04	$253.09
N	$161.76	$147.05	$185.92	$169.02
N Plus	$185.15	$170.44	$209.31	$192.41
G Select	$195.64	$177.86	$224.86	$204.43
G Select Plus	$219.03	$201.25	$248.25	$227.82

Age 74				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$191.96	$174.53	$220.66	$200.61
F	$258.84	$235.31	$297.52	$270.47
F Plus	$282.23	$258.70	$320.91	$293.86
G	$229.12	$208.30	$263.38	$239.44
G Plus	$252.51	$231.69	$286.77	$262.83
N	$169.06	$153.70	$194.33	$176.67
N Plus	$192.45	$177.09	$217.72	$200.06
G Select	$203.92	$185.39	$234.41	$213.10
G Select Plus	$227.31	$208.78	$257.80	$236.49

Age 75				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$198.50	$180.47	$228.20	$207.44
F	$268.90	$244.47	$309.10	$281.01
F Plus	$292.29	$267.86	$332.49	$304.40
G	$238.43	$216.77	$274.08	$249.18
G Plus	$261.82	$240.16	$297.47	$272.57
N	$176.37	$160.35	$202.74	$184.31
N Plus	$199.76	$183.74	$226.13	$207.70
G Select	$212.20	$192.93	$243.93	$221.77
G Select Plus	$235.59	$216.32	$267.32	$245.16

Age 76				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$204.24	$185.68	$234.75	$213.41
F	$278.17	$252.88	$319.74	$290.67
F Plus	$301.56	$276.27	$343.13	$314.06
G	$247.77	$225.24	$284.79	$258.91
G Plus	$271.16	$248.63	$308.18	$282.30
N	$182.78	$166.17	$210.07	$190.98
N Plus	$206.17	$189.56	$233.46	$214.37
G Select	$220.52	$200.46	$253.46	$230.43
G Select Plus	$243.91	$223.85	$276.85	$253.82

Age 77				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$209.93	$190.85	$241.31	$219.39
F	$287.40	$261.27	$330.36	$300.32
F Plus	$310.79	$284.66	$353.75	$323.71
G	$256.13	$232.86	$294.41	$267.66
G Plus	$279.52	$256.25	$317.80	$291.05
N	$189.17	$171.99	$217.43	$197.67
N Plus	$212.56	$195.38	$240.82	$221.06
G Select	$227.96	$207.25	$262.02	$238.22
G Select Plus	$251.35	$230.64	$285.41	$261.61

Age 78				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$214.85	$195.33	$246.96	$224.50
F	$295.81	$268.92	$340.01	$309.10
F Plus	$319.20	$292.31	$363.40	$332.49
G	$264.54	$240.48	$304.07	$276.44
G Plus	$287.93	$263.87	$327.46	$299.83
N	$195.57	$177.78	$224.78	$204.35
N Plus	$218.96	$201.17	$248.17	$227.74
G Select	$235.44	$214.03	$270.62	$246.03
G Select Plus	$258.83	$237.42	$294.01	$269.42

Age 79				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$218.94	$199.04	$251.64	$228.77
F	$304.21	$276.55	$349.69	$317.90
F Plus	$327.60	$299.94	$373.08	$341.29
G	$271.99	$247.27	$312.63	$284.21
G Plus	$295.38	$270.66	$336.02	$307.60
N	$201.96	$183.60	$232.15	$211.05
N Plus	$225.35	$206.99	$255.54	$234.44
G Select	$242.07	$220.07	$278.24	$252.95
G Select Plus	$265.46	$243.46	$301.63	$276.34

Age 80				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$224.97	$204.53	$258.59	$235.09
F	$312.21	$283.83	$358.86	$326.25
F Plus	$335.60	$307.22	$382.25	$349.64
G	$279.52	$254.11	$321.30	$292.11
G Plus	$302.91	$277.50	$344.69	$315.50
N	$207.58	$188.71	$238.58	$216.90
N Plus	$230.97	$212.10	$261.97	$240.29
G Select	$248.77	$226.16	$285.96	$259.98
G Select Plus	$272.16	$249.55	$309.35	$283.37

Age 81				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$230.90	$209.91	$265.39	$241.28
F	$320.02	$290.92	$367.85	$334.41
F Plus	$343.41	$314.31	$391.24	$357.80
G	$286.92	$260.83	$329.80	$299.82
G Plus	$310.31	$284.22	$353.19	$323.21
N	$213.05	$193.69	$244.90	$222.64
N Plus	$236.44	$217.08	$268.29	$246.03
G Select	$255.36	$232.14	$293.52	$266.84
G Select Plus	$278.75	$255.53	$316.91	$290.23

Age 82				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$236.67	$215.15	$272.03	$247.31
F	$327.64	$297.86	$376.59	$342.38
F Plus	$351.03	$321.25	$399.98	$365.77
G	$294.13	$267.38	$338.06	$307.33
G Plus	$317.52	$290.77	$361.45	$330.72
N	$218.39	$198.55	$251.05	$228.22
N Plus	$241.78	$221.94	$274.44	$251.61
G Select	$261.78	$237.97	$300.87	$273.52
G Select Plus	$285.17	$261.36	$324.26	$296.91

Age 83				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$242.31	$220.29	$278.51	$253.20
F	$335.04	$304.59	$385.11	$350.11
F Plus	$358.43	$327.98	$408.50	$373.50
G	$301.13	$273.76	$346.14	$314.68
G Plus	$324.52	$297.15	$369.53	$338.07
N	$223.61	$203.30	$257.03	$233.67
N Plus	$247.00	$226.69	$280.42	$257.06
G Select	$268.01	$243.65	$308.06	$280.07
G Select Plus	$291.40	$267.04	$331.45	$303.46

Age 84				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$247.82	$225.28	$284.84	$258.93
F	$342.27	$311.16	$393.44	$357.67
F Plus	$365.66	$334.55	$416.83	$381.06
G	$307.96	$279.97	$353.98	$321.81
G Plus	$331.35	$303.36	$377.37	$345.20
N	$228.68	$207.90	$262.88	$238.99
N Plus	$252.07	$231.29	$286.27	$262.38
G Select	$274.08	$249.17	$315.04	$286.41
G Select Plus	$297.47	$272.56	$338.43	$309.80

Age 85				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$253.14	$230.13	$290.98	$264.53
F	$349.33	$317.57	$401.52	$365.03
F Plus	$372.72	$340.96	$424.91	$388.42
G	$314.63	$286.02	$361.64	$328.77
G Plus	$338.02	$309.41	$385.03	$352.16
N	$233.65	$212.41	$268.55	$244.15
N Plus	$257.04	$235.80	$291.94	$267.54
G Select	$280.02	$254.56	$321.86	$292.61
G Select Plus	$303.41	$277.95	$345.25	$316.00

Age 86				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$258.35	$234.87	$296.96	$269.97
F	$356.18	$323.80	$409.39	$372.18
F Plus	$379.57	$347.19	$432.78	$395.57
G	$321.10	$291.91	$369.08	$335.53
G Plus	$344.49	$315.30	$392.47	$358.92
N	$238.44	$216.78	$274.06	$249.15
N Plus	$261.83	$240.17	$297.45	$272.54
G Select	$285.78	$259.80	$328.48	$298.62
G Select Plus	$309.17	$283.19	$351.87	$322.01

Age 87				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$263.41	$239.46	$302.77	$275.25
F	$362.85	$329.86	$417.05	$379.14
F Plus	$386.24	$353.25	$440.44	$402.53
G	$327.42	$297.65	$376.32	$342.12
G Plus	$350.81	$321.04	$399.71	$365.51
N	$243.13	$221.03	$279.46	$254.05
N Plus	$266.52	$244.42	$302.85	$277.44
G Select	$291.40	$264.91	$334.92	$304.49
G Select Plus	$314.79	$288.30	$358.31	$327.88

Age 88				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$268.34	$243.95	$308.45	$280.41
F	$369.30	$335.73	$424.48	$385.89
F Plus	$392.69	$359.12	$447.87	$409.28
G	$333.52	$303.21	$383.35	$348.52
G Plus	$356.91	$326.60	$406.74	$371.91
N	$247.67	$225.17	$284.67	$258.80
N Plus	$271.06	$248.56	$308.06	$282.19
G Select	$296.83	$269.86	$341.18	$310.18
G Select Plus	$320.22	$293.25	$364.57	$333.57

Age 89				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$273.14	$248.31	$313.96	$285.42
F	$375.58	$341.45	$431.72	$392.49
F Plus	$398.97	$364.84	$455.11	$415.88
G	$339.46	$308.60	$390.17	$354.69
G Plus	$362.85	$331.99	$413.56	$378.08
N	$252.08	$229.15	$289.74	$263.41
N Plus	$275.47	$252.54	$313.13	$286.80
G Select	$302.12	$274.65	$347.25	$315.67
G Select Plus	$325.51	$298.04	$370.64	$339.06

Age 90				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$277.78	$252.53	$319.27	$290.25
F	$381.68	$347.00	$438.71	$398.83
F Plus	$405.07	$370.39	$462.10	$422.22
G	$345.23	$313.85	$396.81	$360.75
G Plus	$368.62	$337.24	$420.20	$384.14
N	$256.35	$233.05	$294.66	$267.87
N Plus	$279.74	$256.44	$318.05	$291.26
G Select	$307.25	$279.33	$353.16	$321.07
G Select Plus	$330.64	$302.72	$376.55	$344.46

Age 91				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$282.27	$256.63	$324.45	$294.96
F	$387.59	$352.36	$445.49	$405.00
F Plus	$410.98	$375.75	$468.88	$428.39
G	$350.80	$318.92	$403.21	$366.56
G Plus	$374.19	$342.31	$426.60	$389.95
N	$260.50	$236.81	$299.42	$272.21
N Plus	$283.89	$260.20	$322.81	$295.60
G Select	$312.21	$283.84	$358.86	$326.24
G Select Plus	$335.60	$307.23	$382.25	$349.63

Age 92				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$286.64	$260.58	$329.47	$299.52
F	$393.28	$357.54	$452.06	$410.97
F Plus	$416.67	$380.93	$475.45	$434.36
G	$356.18	$323.80	$409.41	$372.20
G Plus	$379.57	$347.19	$432.80	$395.59
N	$264.50	$240.45	$304.03	$276.40
N Plus	$287.89	$263.84	$327.42	$299.79
G Select	$317.00	$288.18	$364.37	$331.26
G Select Plus	$340.39	$311.57	$387.76	$354.65

Age 93				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$290.85	$264.42	$334.32	$303.93
F	$398.81	$362.56	$458.38	$416.72
F Plus	$422.20	$385.95	$481.77	$440.11
G	$361.40	$328.55	$415.41	$377.66
G Plus	$384.79	$351.94	$438.80	$401.05
N	$268.37	$243.98	$308.48	$280.44
N Plus	$291.76	$267.37	$331.87	$303.83
G Select	$321.65	$292.41	$369.71	$336.12
G Select Plus	$345.04	$315.80	$393.10	$359.51

Age 94				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$294.92	$268.13	$338.98	$308.18
F	$404.13	$367.39	$464.51	$422.29
F Plus	$427.52	$390.78	$487.90	$445.68
G	$366.45	$333.13	$421.20	$382.92
G Plus	$389.84	$356.52	$444.59	$406.31
N	$272.11	$247.38	$312.80	$284.37
N Plus	$295.50	$270.77	$336.19	$307.76
G Select	$326.14	$296.49	$374.87	$340.80
G Select Plus	$349.53	$319.88	$398.26	$364.19

Age 95				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$298.88	$271.71	$343.55	$312.31
F	$409.27	$372.07	$470.42	$427.67
F Plus	$432.66	$395.46	$493.81	$451.06
G	$371.30	$337.55	$426.79	$387.98
G Plus	$394.69	$360.94	$450.18	$411.37
N	$275.71	$250.65	$316.93	$288.11
N Plus	$299.10	$274.04	$340.32	$311.50
G Select	$330.46	$300.42	$379.84	$345.30
G Select Plus	$353.85	$323.81	$403.23	$368.69

Age 96				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$302.67	$275.17	$347.92	$316.29
F	$414.20	$376.55	$476.08	$432.82
F Plus	$437.59	$399.94	$499.47	$456.21
G	$375.98	$341.81	$432.15	$392.87
G Plus	$399.37	$365.20	$455.54	$416.26
N	$279.19	$253.81	$320.93	$291.77
N Plus	$302.58	$277.20	$344.32	$315.16
G Select	$334.62	$304.21	$384.61	$349.65
G Select Plus	$358.01	$327.60	$408.00	$373.04

Age 97				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$306.35	$278.50	$352.12	$320.12
F	$418.98	$380.88	$481.58	$437.81
F Plus	$442.37	$404.27	$504.97	$461.20
G	$380.46	$345.88	$437.32	$397.57
G Plus	$403.85	$369.27	$460.71	$420.96
N	$282.53	$256.85	$324.75	$295.23
N Plus	$305.92	$280.24	$348.14	$318.62
G Select	$338.61	$307.83	$389.21	$353.84
G Select Plus	$362.00	$331.22	$412.60	$377.23

Age 98				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$309.86	$281.69	$356.17	$323.79
F	$423.52	$385.04	$486.81	$442.56
F Plus	$446.91	$408.43	$510.20	$465.95
G	$384.78	$349.81	$442.30	$402.08
G Plus	$408.17	$373.20	$465.69	$425.47
N	$285.73	$259.77	$328.44	$298.58
N Plus	$309.12	$283.16	$351.83	$321.97
G Select	$342.45	$311.33	$393.65	$357.85
G Select Plus	$365.84	$334.72	$417.04	$381.24

Age 99				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$313.22	$284.75	$360.02	$327.30
F	$427.92	$389.03	$491.86	$447.15
F Plus	$451.31	$412.42	$515.25	$470.54
G	$388.93	$353.58	$447.04	$406.41
G Plus	$412.32	$376.97	$470.43	$429.80
N	$288.82	$262.57	$331.98	$301.80
N Plus	$312.21	$285.96	$355.37	$325.19
G Select	$346.15	$314.69	$397.87	$361.70
G Select Plus	$369.54	$338.08	$421.26	$385.09

Age 100 +				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$316.46	$287.69	$363.76	$330.70
F	$432.08	$392.82	$496.67	$451.53
F Plus	$455.47	$416.21	$520.06	$474.92
G	$392.89	$357.17	$451.60	$410.54
G Plus	$416.28	$380.56	$474.99	$433.93
N	$291.75	$265.22	$335.35	$304.87
N Plus	$315.14	$288.61	$358.74	$328.26
G Select	$349.67	$317.88	$401.92	$365.38
G Select Plus	$373.06	$341.27	$425.31	$388.77

You have the option to purchase any of the Medicare Supplement benefit plans shown on the front cover in white as Standard Plans or as Medicare Select Plans, with the exception of Plan A, F, F Plus, N and N Plus. Those plans are available as Standard Plans only. Medicare Select Plans require that you use Blue Cross and Blue Shield of Illinois contracting Medicare Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the $1,676 deductible is covered at any hospital from which you receive care. Only certain hospitals are network providers under this policy. Check with your physician to determine if he or she has admitting privileges at the network hospital. If he or she does not, you may be required to use another physician at time of hospitalization or you will be required to pay for all expenses. If you move out of the service area or out of state for this Medicare Select Plan, there will be a reduction of benefit coverage and you will have the opportunity to purchase any Medicare Supplement policy with comparable or lesser benefits offered by the insurer, or Medicare Supplement/Select plans A, B, C, D, F, G, K, or L from any insurer within 63 days of termination. (Note: Plans C and F are no longer available to people new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy Plan C or Plan F. People new to Medicare on or after January 1, 2020, have the right to buy Plans D and G instead of Plans C and F.)

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

A Blue Cross and Blue Shield of Illinois Medicare Supplement premium discount 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 is permitted.

Household Discount

You may be eligible for a discount if you reside with a spouse or civil union/domestic partner or have resided with as many as three adults age 60 or older for the last 12 months. Applies to BCBSIL Medicare Supplement policies issued with an effective date on or after May 1, 2019. The discount is 10%.

Continue with Blue℠ Discount

You may be eligible for a discount if you enrolled in a BCBSIL Medicare Supplement policy issued with an effective date on or after April 1, 2022 and you were enrolled in a Blue Cross and Blue Shield commercial group or individual health insurance coverage plan and that coverage was within one year of your BCBSIL Medicare Supplement policy becoming effective. The discount is 7%.

Blue Family Discount℠

You may be eligible for a discount if you enrolled in a BCBSIL Medicare Supplement policy issued with an effective date on or after April 1, 2024 and you meet the criteria for both the Household Discount AND the Continue with Blue Discount. The discount is 12%.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN 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.

MEDICARE SELECT ADDITIONAL DISCLOSURES

GRIEVANCE PROCEDURES

Our goal is your 100% satisfaction with our processing of your coverage. Should you ever not be fully satisfied with any aspect of the services you receive, we want to know about it so we can correct it.

If you have any dissatisfaction with your Medicare Select coverage, please send all written grievances within 60 days of the occurrence of your dissatisfaction to: **Medicare Supplement Grievance Committee, P.O. Box 3004, Naperville, IL 60566-9747 or fax (888) 235-2949.**

Your grievance will be reviewed by our Grievance Committee. Upon review of your grievance, we will mail you a response within 30 days from the receipt of your written correspondence. If additional information from an outside source is required, we may require an additional 30 days to research, finalize and respond to your correspondence. In no case will a complete response from us take more than 60 days.

If you are dissatisfied with the decision of our Grievance Committee you may submit a written complaint to the **Illinois Insurance Department, 320 Washington Street, 4th Floor, Springfield, Illinois 62766 or call (217) 782-4515**.

QUALITY ASSURANCE

As part of our Quality Assurance program, all contracted hospitals must meet Medicare standards.

In addition, hospitals must meet the contract criteria stated in the Hospital Agreement.

Each hospital must: agree to maintain its state licensure; agree to maintain its Blue Cross and Blue Shield of Illinois Plan Hospital status; agree to maintain its Medicare participating status; be accredited and maintain its accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA); and agree to waive the Part A deductible.

MEDICARE SELECT HOSPITAL RESTRICTIONS

Plans F, G, G Plus, K, L and N are Medicare Select policies currently available if you live within 30 miles of a Medicare Select hospital. Part A benefits may be restricted if you receive services in a hospital that is not a Medicare Select Hospital. NOTE: HISC only offers the Medicare Select option on Plans G and G Plus.

The full benefits of your coverage, excluding Plan K & L coinsurance, will be paid anywhere if:

1. Services are provided in a Doctor's office, another office setting, or in a skilled nursing facility;
2. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or condition and it is not reasonable to obtain such services from a Medicare Select Hospital (such as while you are traveling); or
3. Covered services are not available through a Medicare Select Hospital.

Plan A

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

Services	Medicare Pays	Plan A Pays	You Pay
Hospitalization[5] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$0	$1,676 (Part A deductible)
61st through 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $838 a day	$838 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[6]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[5] 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 $209.50 a day	$0	Up to $209.50 a day
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

[5] 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.

[6] 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
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-approved amounts[7]	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-approved amounts[7]	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan A Pays	You Pay
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $257 of Medicare-approved amounts[7]	$0	$0	$257 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0

[7] Once you have been billed $257 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
Hospitalization[5] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st through 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $838 a day	$838 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[6]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[5] 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 $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

Plan F

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan F Pays**	**You Pay**
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-approved amounts[7]	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-approved amounts[7]	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0
MEDICARE (PARTS A & B)			
Services	**Medicare Pays**	**Plan F Pays**	**You Pay**
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $257 of Medicare-approved amounts[7]	$0	$257 (Part B deductible)	$0
– Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan F Plus

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

Services	Medicare Pays	Plan F Plus Pays	You Pay
Hospitalization[5] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st through 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $838 a day	$838 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[6]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[5] 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 $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

Plan F Plus

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan F Plus Pays**	**You Pay**
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-approved amounts[7]	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-approved amounts[7]	$0	$257 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0
MEDICARE (PARTS A & B)			
Services	**Medicare Pays**	**Plan F Plus Pays**	**You Pay**
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $257 of Medicare-approved amounts[7]	$0	$257 (Part B deductible)	$0
– Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan F Plus

INNOVATIVE BENEFITS			
DENTAL			
Services	**Medicare Pays**	**Plan F Plus Pays**	**You Pay**
Diagnostic Evaluations			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Preventive Services			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Diagnostic Radiographs			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Basic Restorative Services[8]	$0	50%	50%
Non-Surgical Extractions			
In Network	$0	75%	25%
Out of Network	$0	50%	50%
VISION			
Services	**Medicare Pays**	**Plan F Plus Pays**	**You Pay**
Annual Routine Examination			
In Network	$0	100%	$0
Out of Network	$0	All except $40	$40
Materials Allowance			
In Network	$0	$130	Remaining Balance
Out of Network	$0	$65	Remaining Balance
HEARING[9]			
Services	**Medicare Pays**	**Plan F Plus Pays**	**You Pay**
Annual Routine Examination	$0	100%	$0
Hardware Discounts	$0	Generally 30%	Remaining Balance

[8] Once per tooth per calendar year.

[9] All services must be received in network.

Plan G

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

Services	Medicare Pays	Plan G Pays	You Pay
Hospitalization[5] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st through 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $838 a day	$838 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[6]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[5] 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 $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

Plan G

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan G Pays**	**You Pay**
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-approved amounts[7]	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-approved amounts[7]	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0
MEDICARE (PARTS A & B)			
Services	**Medicare Pays**	**Plan G Pays**	**You Pay**
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $257 of Medicare-approved amounts[7]	$0	$0	$257 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan G Plus

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Hospitalization[5] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st through 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $838 a day	$838 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[6]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[5] 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 $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

Plan G Plus

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-approved amounts[7]	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-approved amounts[7]	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0
MEDICARE (PARTS A & B)			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $257 of Medicare-approved amounts[7]	$0	$0	$257 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan G Plus

INNOVATIVE BENEFITS			
DENTAL			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Diagnostic Evaluations			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Preventive Services			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Diagnostic Radiographs			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Basic Restorative Services[8]	$0	50%	50%
Non-Surgical Extractions			
In Network	$0	75%	25%
Out of Network	$0	50%	50%
VISION			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Annual Routine Examination			
In Network	$0	100%	$0
Out of Network	$0	All except $40	$40
Materials Allowance			
In Network	$0	$130	Remaining Balance
Out of Network	$0	$65	Remaining Balance
HEARING[9]			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Annual Routine Examination	$0	100%	$0
Hardware Discounts	$0	Generally 30%	Remaining Balance

Plan N

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD			
Services	**Medicare Pays**	**Plan N Pays**	**You Pay**
Hospitalization[5] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st through 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $838 a day	$838 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[6]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[5] 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 $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

Plan N

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan N Pays**	**You Pay**
Medical Expenses — In or Out of the Hospital And Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-approved amounts[7]	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-approved amounts[7]	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A & B)			
Services	**Medicare Pays**	**Plan N Pays**	**You Pay**
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $257 of Medicare-approved amounts[7]	$0	$0	$257 (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**
Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan N Plus

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

Services	Medicare Pays	Plan N Plus Pays	You Pay
Hospitalization[5] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A deductible)	$0
61st through 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $838 a day	$838 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[6]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[5] 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 $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

Plan N Plus

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

Services	Medicare Pays	Plan N Plus Pays	You Pay
Medical Expenses — In or Out of the Hospital And Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-approved amounts[7]	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-approved amounts[7]	$0	$0	$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan N Plus Pays	You Pay
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $257 of Medicare-approved amounts[7]	$0	$0	$257 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0

Plan N Plus

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

Plan N Plus

INNOVATIVE BENEFITS			
DENTAL			
Services	**Medicare Pays**	**Plan N Plus Pays**	**You Pay**
Diagnostic Evaluations			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Preventive Services			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Diagnostic Radiographs			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Basic Restorative Services[8]	$0	50%	50%
Non-Surgical Extractions			
In Network	$0	75%	25%
Out of Network	$0	50%	50%
VISION			
Services	**Medicare Pays**	**Plan N Plus Pays**	**You Pay**
Annual Routine Examination			
In Network	$0	100%	$0
Out of Network	$0	All except $40	$40
Materials Allowance			
In Network	$0	$130	Remaining Balance
Out of Network	$0	$65	Remaining Balance
HEARING[9]			
Services	**Medicare Pays**	**Plan N Plus Pays**	**You Pay**
Annual Routine Examination	$0	100%	$0
Hardware Discounts	$0	Generally 30%	Remaining Balance

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.

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