



**BlueCross BlueShield** 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



# BENEFIT OF BLUE<sup>®</sup>



## Medicare Supplement Insurance Benefits Guide

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

This information is a solicitation for insurance.

ILMSDG24

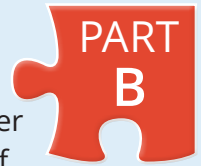
# How Does Medicare Work?

There are four parts to Medicare, each providing different types of health care services. Medicare Supplement insurance is often added to Parts A, B and D to form more complete medical coverage.



## Hospital Insurance

Helps pay for inpatient hospital care, skilled nursing facility care, home health care, and hospice care. While most Americans are enrolled automatically in Medicare Part A, it may not cover all of your health care costs. Parts B, C and D are voluntary programs that provide additional coverage.



## Medical Insurance

Helps pay for covered doctor's services and many other medical services and supplies. If you don't enroll in Part B when you are first eligible, you may have to pay a penalty later.



## Medicare Advantage Plans

Offers medical coverage through a network of providers, such as an HMO or PPO, that is an alternative to Original Medicare (Parts A and B). These plans may or may not cover prescription drugs.



## Prescription Drug Coverage

Helps pay for covered prescription medications. As with Part B, if you do not enroll when first eligible, you may have to pay a penalty later.

## Medicare Supplement Insurance

Optional coverage helps to pay for expenses beyond what is covered by Medicare. There are several Medicare Supplement Insurance Plans, each with different benefits and premiums, so you can choose the plan that works best for your specific needs. Medicare Supplement Insurance Plans are identified by the separate letters A through N. The basic benefits of each plan are exactly alike for all insurance companies.

If you are already a member of a Medicare Advantage plan, you cannot purchase a Medicare Supplement Insurance Plan.



Learn more about your Medicare Supplement insurance options at [www.getblueil.com/medsupp](http://www.getblueil.com/medsupp)

# What Are My Plan Options and Coverage?

Medicare Supplement Insurance Plans offered by Blue Cross and Blue Shield of Illinois are outlined in the table below. Each plan offers a different set of benefits.

Plans F and High Deductible F are also available but only if you were eligible for Medicare before January 1, 2020.

Plans K and L are no longer available for new enrollees. Existing K and L members will be able to keep their plan.

|                                                                                        | Plan A | Plan F <sup>3,4</sup> | Plan F Plus | Plan G | Plan G Plus | Plan N                          | Plan N Plus                     |
|----------------------------------------------------------------------------------------|--------|-----------------------|-------------|--------|-------------|---------------------------------|---------------------------------|
| <b>Medicare Select Option Available<sup>7</sup></b><br>(eligibility based on ZIP code) |        | ✓                     |             | ✓      | ✓           | ✓                               |                                 |
| <b>Basic Benefits</b>                                                                  | ✓      | ✓                     | ✓           | ✓      | ✓           | ✓<br>copay applies <sup>1</sup> | ✓<br>copay applies <sup>2</sup> |
| <b>Skilled Nursing Coinsurance</b>                                                     |        | ✓                     | ✓           | ✓      | ✓           | ✓                               | ✓                               |
| <b>Part A Deductible</b>                                                               |        | ✓                     | ✓           | ✓      | ✓           | ✓                               | ✓                               |
| <b>Part B Excess<sup>5</sup></b>                                                       |        | ✓                     | ✓           | ✓      | ✓           |                                 |                                 |
| <b>Foreign Travel Emergency Care<sup>6</sup></b>                                       |        | ✓                     | ✓           | ✓      | ✓           | ✓                               | ✓                               |
| <b>24/7 Nurseline</b>                                                                  | ✓      | ✓                     | ✓           | ✓      | ✓           | ✓                               | ✓                               |
| <b>SilverSneakers® Fitness Program</b>                                                 |        |                       | ✓           |        | ✓           |                                 | ✓                               |
| <b>Dental Benefits</b>                                                                 |        |                       | ✓           |        | ✓           |                                 | ✓                               |
| <b>Hearing Benefits</b>                                                                | ✓      | ✓                     | ✓           | ✓      | ✓           | ✓                               | ✓                               |
| <b>Vision Benefits</b>                                                                 |        |                       | ✓           |        | ✓           |                                 | ✓                               |

# What Does a Medicare Supplement Insurance Plan Cover?

Medicare Supplement Insurance Plans cover the costs that Original Medicare does not cover on deductibles, coinsurance and copayments. With your Medicare Supplement Insurance Plan, you can choose any doctor or specialist who accepts Medicare. At the time of your doctor visit, there is no cost up front. Just show your member ID, and your claim will be sent to Medicare and then sent electronically to us.

Plan G Plus and High Deductible Plan G Plus include coverage of dental benefits for cleanings, exams and X-rays; hearing benefits of a \$0 annual exam with hearing aid discounts; free SilverSneakers® Fitness Program; and access to the 24/7 Nurseline. Medicare Supplement Insurance Plans do not cover prescription drugs, but they can be paired with a prescription drug plan.

## Deductibles

The amount you must pay for health care before Original Medicare begins to pay.

## Coinsurance

An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

## Copayments

An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor, hospital or outpatient visit. A copayment is usually a set amount, rather than a percentage.

- <sup>1</sup> Plan N requires a copayment of up to \$20 for office visits and a copayment of up to \$50 for Emergency Room visits
- <sup>2</sup> Plan N Plus requires a copayment of up to \$20 for office visits and a copayment of up to \$50 for Emergency Room visits.
- <sup>3</sup> This high deductible option requires a member to pay a 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 and Plan G Plus does not cover the Medicare Part B deductible.
- <sup>4</sup> Plan F, Plan F Select and High Deductible F are only available if you are Medicare eligible prior to 2020.
- <sup>5</sup> Not to exceed any charge limitation by the Medicare program or state law.
- <sup>6</sup> Plans cover care needed immediately because of an illness of sudden and unexpected onset, which care began during the first 60 consecutive days of travel outside the United States
- <sup>7</sup> 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.

SilverSneakers® is a wellness program owned and operated by Tivity Health, Inc., an independent company. Tivity Health and SilverSneakers® are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and /or affiliates in the USA and/or other countries.

# A Name You Can Trust

Blue Cross and Blue Shield of Illinois is a name you can trust, and we have been serving the people of Illinois for more than 88 years. Our Medicare Supplement Insurance Plans offer in-depth coverage to help protect your health while also offering our high-level customer service and additional benefits.

## Here Are Great Reasons to Choose Blue Cross and Blue Shield of Illinois:

1. A choice of seven BCBSIL Medicare Supplement Insurance Plans to help you cover Medicare gaps.
2. Virtually hassle-free claims processing.
3. A name recognized by doctors and specialists everywhere.
4. Reliable coverage from a respected industry leader.
5. Helpful personalized individual service from Medicare Supplement agents to answer your questions.
6. Medicare Select is a money-saving option for members who live within 30 miles of a contracting hospital. It has all the same benefits as a standard option, but it costs less as long as a member uses Medicare Select hospitals for non-emergency admissions.
7. Over 88 years of experience, know-how and service to Illinois residents.
8. Medicare Supplement insurance also has value-added benefits that include an annual hearing exam, hearing aid discounts, and access to a 24/7 Nurseline.
9. Easy, online application is available.



### Continue with Blue<sup>SM</sup> 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%.

### 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 Blue Cross and Blue Shield of Illinois Medicare Supplement policies issued with an effective date on or after May 1, 2019. The Discount is 10%.

### Blue Family Discount<sup>SM</sup> \*

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%.

\* Discounts cannot be combined; only one type of discount per enrollee permitted.



**BlueCross BlueShield** 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

## Make the Right Choice for Your Peace of Mind.



### Call

Toll Free: **1-877-260-0298 • TTY 711**

8:00 a.m. – 8:00 p.m., local time, Monday through Friday



### Web

**[www.getblueil.com/medsupp](http://www.getblueil.com/medsupp)**

### Seminars: An Insurance Sales Presentation

**Find a free seminar near you: [www.bcbsil.com/medicare/seminars](http://www.bcbsil.com/medicare/seminars)**

The best time to buy a Medicare Supplement insurance policy is around the time you turn 65. You have guaranteed acceptance on the first day of the month in which you turn 65 and are enrolled in Medicare Part B. If you are under age 65, have Medicare Part A and are enrolled in Medicare Part B, your acceptance is guaranteed within six months of your Part B effective date or another qualifying event. In any scenario, you must have Medicare Part B to be eligible for a Medicare Supplement insurance policy.

SilverSneakers® is a wellness program owned and operated by Tivity Health, Inc., an independent company.

Tivity Health and SilverSneakers® are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries.

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

#### *Medicare Supplement Insurance Plan Notice:*

Medicare Supplement insurance plans are offered by 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.

Blue Cross and Blue Shield of Illinois, 300 E. Randolph St., Chicago, IL 60601

ILMSDG24

32101.1124



**BlueCross BlueShield** of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

Outline of Medicare Supplement Coverage —  
Standard Benefits for Plan A, High Deductible  
Plan F<sup>1</sup>, Plan F Plus, High Deductible Plan G<sup>1</sup>, High  
Deductible Plan G Plus<sup>1</sup>; and Plan N Plus Standard  
and Medicare Select Benefits<sup>4</sup> for Plan F, Plan G,  
Plan G Plus, and Plan N

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 <sup>1</sup> | K <sup>2</sup>       | L <sup>2</sup>       | M   | N                         | C                                        | F <sup>1</sup> |
| 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 <sup>3</sup> | ✓                                        | ✓              |
| 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 <sup>2</sup>                                                                             |                                   |   |   |                | \$7,220 <sup>2</sup> | \$3,610 <sup>2</sup> |     |                           |                                          |                |

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

- <sup>1</sup> 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.
- <sup>2</sup> 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.
- <sup>3</sup> 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.
- <sup>4</sup> 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     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$154.26 | \$140.24    | N/A                     | N/A         | \$175.82 | \$159.82    | N/A                     | N/A         |
| F                        | \$242.36 | \$220.32    | \$215.69                | \$196.09    | \$276.21 | \$251.09    | \$245.83                | \$223.47    |
| High F <sup>1</sup>      | \$69.62  | \$63.29     | N/A                     | N/A         | \$79.34  | \$72.14     | N/A                     | N/A         |
| F Plus                   | \$265.75 | \$243.71    | N/A                     | N/A         | \$299.60 | \$274.48    | N/A                     | N/A         |
| G                        | \$192.65 | \$175.16    | \$171.46                | \$155.88    | \$222.89 | \$202.62    | \$198.37                | \$180.34    |
| High G <sup>1</sup>      | \$66.29  | \$60.27     | N/A                     | N/A         | \$75.57  | \$68.71     | N/A                     | N/A         |
| G Plus                   | \$216.04 | \$198.55    | \$194.85                | \$179.27    | \$246.28 | \$226.01    | \$221.76                | \$203.73    |
| High G Plus <sup>1</sup> | \$89.68  | \$83.66     | N/A                     | N/A         | \$98.96  | \$92.10     | N/A                     | N/A         |
| N                        | \$167.69 | \$152.45    | \$149.25                | \$135.68    | \$194.01 | \$176.37    | \$172.67                | \$156.96    |
| N Plus                   | \$191.08 | \$175.84    | N/A                     | N/A         | \$217.40 | \$199.76    | N/A                     | N/A         |

## Age 66

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$163.82 | \$148.91    | N/A                     | N/A         | \$186.70 | \$169.72    | N/A                     | N/A         |
| F                        | \$257.33 | \$233.96    | \$229.04                | \$208.22    | \$293.29 | \$266.63    | \$261.05                | \$237.29    |
| High F <sup>1</sup>      | \$73.93  | \$67.19     | N/A                     | N/A         | \$84.25  | \$76.58     | N/A                     | N/A         |
| F Plus                   | \$280.72 | \$257.35    | N/A                     | N/A         | \$316.68 | \$290.02    | N/A                     | N/A         |
| G                        | \$206.06 | \$187.33    | \$183.39                | \$166.72    | \$238.14 | \$216.51    | \$211.95                | \$192.68    |
| High G <sup>1</sup>      | \$70.41  | \$64.00     | N/A                     | N/A         | \$80.24  | \$72.95     | N/A                     | N/A         |
| G Plus                   | \$229.45 | \$210.72    | \$206.78                | \$190.11    | \$261.53 | \$239.90    | \$235.34                | \$216.07    |
| High G Plus <sup>1</sup> | \$93.80  | \$87.39     | N/A                     | N/A         | \$103.63 | \$96.34     | N/A                     | N/A         |
| N                        | \$179.33 | \$163.04    | \$159.63                | \$145.11    | \$207.27 | \$188.44    | \$184.49                | \$167.71    |
| N Plus                   | \$202.72 | \$186.43    | N/A                     | N/A         | \$230.66 | \$211.83    | N/A                     | N/A         |

# Age 67

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$173.19 | \$157.44    | N/A                     | N/A         | \$197.37 | \$179.43    | N/A                     | N/A         |
| F                        | \$272.05 | \$247.34    | \$242.14                | \$220.13    | \$310.09 | \$281.88    | \$275.96                | \$250.88    |
| High F <sup>1</sup>      | \$78.15  | \$71.06     | N/A                     | N/A         | \$89.08  | \$80.96     | N/A                     | N/A         |
| F Plus                   | \$295.44 | \$270.73    | N/A                     | N/A         | \$333.48 | \$305.27    | N/A                     | N/A         |
| G                        | \$219.19 | \$199.28    | \$195.06                | \$177.35    | \$253.12 | \$230.10    | \$225.28                | \$204.80    |
| High G <sup>1</sup>      | \$74.43  | \$67.67     | N/A                     | N/A         | \$84.83  | \$77.11     | N/A                     | N/A         |
| G Plus                   | \$242.58 | \$222.67    | \$218.45                | \$200.74    | \$276.51 | \$253.49    | \$248.67                | \$228.19    |
| High G Plus <sup>1</sup> | \$97.82  | \$91.06     | N/A                     | N/A         | \$108.22 | \$100.50    | N/A                     | N/A         |
| N                        | \$190.78 | \$173.45    | \$169.81                | \$154.37    | \$220.32 | \$200.29    | \$196.09                | \$178.26    |
| N Plus                   | \$214.17 | \$196.84    | N/A                     | N/A         | \$243.71 | \$223.68    | N/A                     | N/A         |

# Age 68

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$182.39 | \$165.80    | N/A                     | N/A         | \$207.86 | \$188.98    | N/A                     | N/A         |
| F                        | \$286.52 | \$260.47    | \$254.99                | \$231.81    | \$326.55 | \$296.87    | \$290.63                | \$264.21    |
| High F <sup>1</sup>      | \$82.31  | \$74.83     | N/A                     | N/A         | \$93.81  | \$85.26     | N/A                     | N/A         |
| F Plus                   | \$309.91 | \$283.86    | N/A                     | N/A         | \$349.94 | \$320.26    | N/A                     | N/A         |
| G                        | \$232.10 | \$211.00    | \$206.58                | \$187.78    | \$267.83 | \$243.49    | \$238.38                | \$216.70    |
| High G <sup>1</sup>      | \$78.39  | \$71.26     | N/A                     | N/A         | \$89.33  | \$81.21     | N/A                     | N/A         |
| G Plus                   | \$255.49 | \$234.39    | \$229.97                | \$211.17    | \$291.22 | \$266.88    | \$261.77                | \$240.09    |
| High G Plus <sup>1</sup> | \$101.78 | \$94.65     | N/A                     | N/A         | \$112.72 | \$104.60    | N/A                     | N/A         |
| N                        | \$202.03 | \$183.65    | \$179.80                | \$163.45    | \$233.12 | \$211.94    | \$207.49                | \$188.63    |
| N Plus                   | \$225.42 | \$207.04    | N/A                     | N/A         | \$256.51 | \$235.33    | N/A                     | N/A         |

# Age 69

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$191.41 | \$174.02    | N/A                     | N/A         | \$218.16 | \$198.31    | N/A                     | N/A         |
| F                        | \$300.72 | \$273.38    | \$267.62                | \$243.31    | \$342.73 | \$311.56    | \$305.01                | \$277.30    |
| High F <sup>1</sup>      | \$86.39  | \$78.52     | N/A                     | N/A         | \$98.46  | \$89.52     | N/A                     | N/A         |
| F Plus                   | \$324.11 | \$296.77    | N/A                     | N/A         | \$366.12 | \$334.95    | N/A                     | N/A         |
| G                        | \$244.78 | \$222.51    | \$217.84                | \$198.03    | \$282.27 | \$256.60    | \$251.22                | \$228.38    |
| High G <sup>1</sup>      | \$82.27  | \$74.80     | N/A                     | N/A         | \$93.77  | \$85.24     | N/A                     | N/A         |
| G Plus                   | \$268.17 | \$245.90    | \$241.23                | \$221.42    | \$305.66 | \$279.99    | \$274.61                | \$251.77    |
| High G Plus <sup>1</sup> | \$105.66 | \$98.19     | N/A                     | N/A         | \$117.16 | \$108.63    | N/A                     | N/A         |
| N                        | \$213.05 | \$193.68    | \$189.61                | \$172.38    | \$245.70 | \$223.34    | \$218.67                | \$198.78    |
| N Plus                   | \$236.44 | \$217.07    | N/A                     | N/A         | \$269.09 | \$246.73    | N/A                     | N/A         |

# Age 70

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$200.27 | \$182.07    | N/A                     | N/A         | \$228.25 | \$207.51    | N/A                     | N/A         |
| F                        | \$314.63 | \$286.02    | \$280.02                | \$254.57    | \$358.60 | \$326.01    | \$319.15                | \$290.13    |
| High F <sup>1</sup>      | \$90.39  | \$82.16     | N/A                     | N/A         | \$103.01 | \$93.65     | N/A                     | N/A         |
| F Plus                   | \$338.02 | \$309.41    | N/A                     | N/A         | \$381.99 | \$349.40    | N/A                     | N/A         |
| G                        | \$257.18 | \$233.81    | \$228.90                | \$208.08    | \$296.44 | \$269.50    | \$263.82                | \$239.84    |
| High G <sup>1</sup>      | \$86.08  | \$78.25     | N/A                     | N/A         | \$98.10  | \$89.19     | N/A                     | N/A         |
| G Plus                   | \$280.57 | \$257.20    | \$252.29                | \$231.47    | \$319.83 | \$292.89    | \$287.21                | \$263.23    |
| High G Plus <sup>1</sup> | \$109.47 | \$101.64    | N/A                     | N/A         | \$121.49 | \$112.58    | N/A                     | N/A         |
| N                        | \$223.87 | \$203.51    | \$199.23                | \$181.12    | \$258.03 | \$234.57    | \$229.63                | \$208.77    |
| N Plus                   | \$247.26 | \$226.90    | N/A                     | N/A         | \$281.42 | \$257.96    | N/A                     | N/A         |

# Age 71

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$208.95 | \$189.96    | N/A                     | N/A         | \$238.16 | \$216.51    | N/A                     | N/A         |
| F                        | \$328.28 | \$298.44    | \$292.19                | \$265.62    | \$374.16 | \$340.12    | \$332.99                | \$302.71    |
| High F <sup>1</sup>      | \$94.30  | \$85.75     | N/A                     | N/A         | \$107.47 | \$97.70     | N/A                     | N/A         |
| F Plus                   | \$351.67 | \$321.83    | N/A                     | N/A         | \$397.55 | \$363.51    | N/A                     | N/A         |
| G                        | \$269.39 | \$244.88    | \$239.75                | \$217.96    | \$310.34 | \$282.11    | \$276.20                | \$251.08    |
| High G <sup>1</sup>      | \$89.82  | \$81.65     | N/A                     | N/A         | \$102.36 | \$93.04     | N/A                     | N/A         |
| G Plus                   | \$292.78 | \$268.27    | \$263.14                | \$241.35    | \$333.73 | \$305.50    | \$299.59                | \$274.47    |
| High G Plus <sup>1</sup> | \$113.21 | \$105.04    | N/A                     | N/A         | \$125.75 | \$116.43    | N/A                     | N/A         |
| N                        | \$234.48 | \$213.16    | \$208.68                | \$189.72    | \$270.12 | \$245.54    | \$240.40                | \$218.53    |
| N Plus                   | \$257.87 | \$236.55    | N/A                     | N/A         | \$293.51 | \$268.93    | N/A                     | N/A         |

# Age 72

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$217.49 | \$197.72    | N/A                     | N/A         | \$247.86 | \$225.34    | N/A                     | N/A         |
| F                        | \$341.68 | \$310.60    | \$304.08                | \$276.43    | \$389.41 | \$354.02    | \$346.57                | \$315.08    |
| High F <sup>1</sup>      | \$98.16  | \$89.24     | N/A                     | N/A         | \$111.86 | \$101.69    | N/A                     | N/A         |
| F Plus                   | \$365.07 | \$333.99    | N/A                     | N/A         | \$412.80 | \$377.41    | N/A                     | N/A         |
| G                        | \$281.34 | \$255.75    | \$250.39                | \$227.62    | \$323.94 | \$294.49    | \$288.33                | \$262.11    |
| High G <sup>1</sup>      | \$93.48  | \$84.98     | N/A                     | N/A         | \$106.53 | \$96.85     | N/A                     | N/A         |
| G Plus                   | \$304.73 | \$279.14    | \$273.78                | \$251.01    | \$347.33 | \$317.88    | \$311.72                | \$285.50    |
| High G Plus <sup>1</sup> | \$116.87 | \$108.37    | N/A                     | N/A         | \$129.92 | \$120.24    | N/A                     | N/A         |
| N                        | \$244.88 | \$222.63    | \$217.95                | \$198.12    | \$281.97 | \$256.35    | \$250.95                | \$228.12    |
| N Plus                   | \$268.27 | \$246.02    | N/A                     | N/A         | \$305.36 | \$279.74    | N/A                     | N/A         |

# Age 73

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$225.85 | \$205.31    | N/A                     | N/A         | \$257.39 | \$234.00    | N/A                     | N/A         |
| F                        | \$354.79 | \$322.55    | \$315.76                | \$287.07    | \$404.36 | \$367.59    | \$359.88                | \$327.15    |
| High F <sup>1</sup>      | \$101.92 | \$92.66     | N/A                     | N/A         | \$116.17 | \$105.59    | N/A                     | N/A         |
| F Plus                   | \$378.18 | \$345.94    | N/A                     | N/A         | \$427.75 | \$390.98    | N/A                     | N/A         |
| G                        | \$293.04 | \$266.39    | \$260.80                | \$237.11    | \$337.29 | \$306.63    | \$300.20                | \$272.90    |
| High G <sup>1</sup>      | \$97.06  | \$88.25     | N/A                     | N/A         | \$110.63 | \$100.57    | N/A                     | N/A         |
| G Plus                   | \$316.43 | \$289.78    | \$284.19                | \$260.50    | \$360.68 | \$330.02    | \$323.59                | \$296.29    |
| High G Plus <sup>1</sup> | \$120.45 | \$111.64    | N/A                     | N/A         | \$134.02 | \$123.96    | N/A                     | N/A         |
| N                        | \$255.08 | \$231.88    | \$227.00                | \$206.38    | \$293.60 | \$266.89    | \$261.28                | \$237.55    |
| N Plus                   | \$278.47 | \$255.27    | N/A                     | N/A         | \$316.99 | \$290.28    | N/A                     | N/A         |

# Age 74

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$234.02 | \$212.73    | N/A                     | N/A         | \$266.71 | \$242.45    | N/A                     | N/A         |
| F                        | \$367.64 | \$334.21    | \$327.19                | \$297.44    | \$419.00 | \$380.91    | \$372.91                | \$339.02    |
| High F <sup>1</sup>      | \$105.61 | \$96.01     | N/A                     | N/A         | \$120.36 | \$109.42    | N/A                     | N/A         |
| F Plus                   | \$391.03 | \$357.60    | N/A                     | N/A         | \$442.39 | \$404.30    | N/A                     | N/A         |
| G                        | \$304.52 | \$276.84    | \$271.02                | \$246.38    | \$350.36 | \$318.53    | \$311.83                | \$283.49    |
| High G <sup>1</sup>      | \$100.58 | \$91.44     | N/A                     | N/A         | \$114.63 | \$104.20    | N/A                     | N/A         |
| G Plus                   | \$327.91 | \$300.23    | \$294.41                | \$269.77    | \$373.75 | \$341.92    | \$335.22                | \$306.88    |
| High G Plus <sup>1</sup> | \$123.97 | \$114.83    | N/A                     | N/A         | \$138.02 | \$127.59    | N/A                     | N/A         |
| N                        | \$265.06 | \$240.96    | \$235.89                | \$214.46    | \$304.95 | \$277.26    | \$271.40                | \$246.75    |
| N Plus                   | \$288.45 | \$264.35    | N/A                     | N/A         | \$328.34 | \$300.65    | N/A                     | N/A         |

# Age 75

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$242.03 | \$220.03    | N/A                     | N/A         | \$275.82 | \$250.76    | N/A                     | N/A         |
| F                        | \$380.21 | \$345.66    | \$338.40                | \$307.63    | \$433.33 | \$393.95    | \$385.69                | \$350.62    |
| High F <sup>1</sup>      | \$109.20 | \$99.28     | N/A                     | N/A         | \$124.47 | \$113.17    | N/A                     | N/A         |
| F Plus                   | \$403.60 | \$369.05    | N/A                     | N/A         | \$456.72 | \$417.34    | N/A                     | N/A         |
| G                        | \$315.74 | \$287.04    | \$281.02                | \$255.46    | \$363.18 | \$330.15    | \$323.23                | \$293.85    |
| High G <sup>1</sup>      | \$104.02 | \$94.56     | N/A                     | N/A         | \$118.54 | \$107.78    | N/A                     | N/A         |
| G Plus                   | \$339.13 | \$310.43    | \$304.41                | \$278.85    | \$386.57 | \$353.54    | \$346.62                | \$317.24    |
| High G Plus <sup>1</sup> | \$127.41 | \$117.95    | N/A                     | N/A         | \$141.93 | \$131.17    | N/A                     | N/A         |
| N                        | \$274.83 | \$249.84    | \$244.60                | \$222.36    | \$316.11 | \$287.37    | \$281.33                | \$255.75    |
| N Plus                   | \$298.22 | \$273.23    | N/A                     | N/A         | \$339.50 | \$310.76    | N/A                     | N/A         |

# Age 76

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$249.86 | \$227.16    | N/A                     | N/A         | \$284.76 | \$258.88    | N/A                     | N/A         |
| F                        | \$392.53 | \$356.86    | \$349.36                | \$317.60    | \$447.38 | \$406.71    | \$398.17                | \$361.97    |
| High F <sup>1</sup>      | \$112.76 | \$102.52    | N/A                     | N/A         | \$128.50 | \$116.84    | N/A                     | N/A         |
| F Plus                   | \$415.92 | \$380.25    | N/A                     | N/A         | \$470.77 | \$430.10    | N/A                     | N/A         |
| G                        | \$326.74 | \$297.04    | \$290.80                | \$264.37    | \$375.71 | \$341.55    | \$334.37                | \$303.97    |
| High G <sup>1</sup>      | \$107.40 | \$97.63     | N/A                     | N/A         | \$122.39 | \$111.28    | N/A                     | N/A         |
| G Plus                   | \$350.13 | \$320.43    | \$314.19                | \$287.76    | \$399.10 | \$364.94    | \$357.76                | \$327.36    |
| High G Plus <sup>1</sup> | \$130.79 | \$121.02    | N/A                     | N/A         | \$145.78 | \$134.67    | N/A                     | N/A         |
| N                        | \$284.40 | \$258.54    | \$253.12                | \$230.10    | \$327.02 | \$297.27    | \$291.05                | \$264.58    |
| N Plus                   | 307.79   | 281.93      | N/A                     | N/A         | \$350.41 | \$320.66    | N/A                     | N/A         |

# Age 77

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$257.54 | \$234.11    | N/A                     | N/A         | \$293.50 | \$266.82    | N/A                     | N/A         |
| F                        | \$404.60 | \$367.81    | \$360.06                | \$327.35    | \$461.10 | \$419.20    | \$410.38                | \$373.07    |
| High F <sup>1</sup>      | \$116.22 | \$105.65    | N/A                     | N/A         | \$132.45 | \$120.41    | N/A                     | N/A         |
| F Plus                   | \$427.99 | \$391.20    | N/A                     | N/A         | \$484.49 | \$442.59    | N/A                     | N/A         |
| G                        | \$337.50 | \$306.82    | \$300.38                | \$273.07    | \$387.96 | \$352.69    | \$345.28                | \$313.90    |
| High G <sup>1</sup>      | \$110.69 | \$100.63    | N/A                     | N/A         | \$126.15 | \$114.68    | N/A                     | N/A         |
| G Plus                   | \$360.89 | \$330.21    | \$323.77                | \$296.46    | \$411.35 | \$376.08    | \$368.67                | \$337.29    |
| High G Plus <sup>1</sup> | \$134.08 | \$124.02    | N/A                     | N/A         | \$149.54 | \$138.07    | N/A                     | N/A         |
| N                        | \$293.76 | \$267.06    | \$261.44                | \$237.67    | \$337.69 | \$307.00    | \$300.55                | \$273.22    |
| N Plus                   | \$317.15 | \$290.45    | N/A                     | N/A         | \$361.08 | \$330.39    | N/A                     | N/A         |

# Age 78

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$265.04 | \$240.94    | N/A                     | N/A         | \$302.05 | \$274.58    | N/A                     | N/A         |
| F                        | \$416.37 | \$378.52    | \$370.56                | \$336.86    | \$474.53 | \$431.39    | \$422.33                | \$383.94    |
| High F <sup>1</sup>      | \$119.61 | \$108.74    | N/A                     | N/A         | \$136.31 | \$123.92    | N/A                     | N/A         |
| F Plus                   | \$439.76 | \$401.91    | N/A                     | N/A         | \$497.92 | \$454.78    | N/A                     | N/A         |
| G                        | \$348.02 | \$316.36    | \$309.73                | \$281.58    | \$399.95 | \$363.58    | \$355.95                | \$323.58    |
| High G <sup>1</sup>      | \$113.90 | \$103.55    | N/A                     | N/A         | \$129.83 | \$118.03    | N/A                     | N/A         |
| G Plus                   | \$371.41 | \$339.75    | \$333.12                | \$304.97    | \$423.34 | \$386.97    | \$379.34                | \$346.97    |
| High G Plus <sup>1</sup> | \$137.29 | \$126.94    | N/A                     | N/A         | \$153.22 | \$141.42    | N/A                     | N/A         |
| N                        | \$302.91 | \$275.38    | \$269.61                | \$245.10    | \$348.12 | \$316.47    | \$309.84                | \$281.65    |
| N Plus                   | \$326.30 | \$298.77    | N/A                     | N/A         | \$371.51 | \$339.86    | N/A                     | N/A         |

# Age 79

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$272.36 | \$247.59    | N/A                     | N/A         | \$310.39 | \$282.18    | N/A                     | N/A         |
| F                        | \$427.88 | \$388.97    | \$380.82                | \$346.19    | \$487.65 | \$443.32    | \$433.99                | \$394.54    |
| High F <sup>1</sup>      | \$122.90 | \$111.75    | N/A                     | N/A         | \$140.09 | \$127.34    | N/A                     | N/A         |
| F Plus                   | \$451.27 | \$412.36    | N/A                     | N/A         | \$511.04 | \$466.71    | N/A                     | N/A         |
| G                        | \$358.29 | \$325.70    | \$318.88                | \$289.91    | \$411.64 | \$374.24    | \$366.38                | \$333.07    |
| High G <sup>1</sup>      | \$117.07 | \$106.42    | N/A                     | N/A         | \$133.41 | \$121.27    | N/A                     | N/A         |
| G Plus                   | \$381.68 | \$349.09    | \$342.27                | \$313.30    | \$435.03 | \$397.63    | \$389.77                | \$356.46    |
| High G Plus <sup>1</sup> | \$140.46 | \$129.81    | N/A                     | N/A         | \$156.80 | \$144.66    | N/A                     | N/A         |
| N                        | \$311.85 | \$283.51    | \$277.56                | \$252.32    | \$358.31 | \$325.74    | \$318.90                | \$289.91    |
| N Plus                   | \$335.24 | \$306.90    | N/A                     | N/A         | \$381.70 | \$349.13    | N/A                     | N/A         |

# Age 80

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$279.51 | \$254.11    | N/A                     | N/A         | \$318.56 | \$289.59    | N/A                     | N/A         |
| F                        | \$439.12 | \$399.18    | \$390.80                | \$355.28    | \$500.47 | \$454.96    | \$445.41                | \$404.93    |
| High F <sup>1</sup>      | \$126.13 | \$114.67    | N/A                     | N/A         | \$143.76 | \$130.71    | N/A                     | N/A         |
| F Plus                   | \$462.51 | \$422.57    | N/A                     | N/A         | \$523.86 | \$478.35    | N/A                     | N/A         |
| G                        | \$368.34 | \$334.84    | \$327.82                | \$298.01    | \$423.10 | \$384.63    | \$376.55                | \$342.32    |
| High G <sup>1</sup>      | \$120.12 | \$109.20    | N/A                     | N/A         | \$136.90 | \$124.47    | N/A                     | N/A         |
| G Plus                   | \$391.73 | \$358.23    | \$351.21                | \$321.40    | \$446.49 | \$408.02    | \$399.94                | \$365.71    |
| High G Plus <sup>1</sup> | \$143.51 | \$132.59    | N/A                     | N/A         | \$160.29 | \$147.86    | N/A                     | N/A         |
| N                        | \$320.60 | \$291.44    | \$285.34                | \$259.38    | \$368.27 | \$334.78    | \$327.75                | \$297.98    |
| N Plus                   | \$343.99 | \$314.83    | N/A                     | N/A         | \$391.66 | \$358.17    | N/A                     | N/A         |

# Age 81

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$286.49 | \$260.45    | N/A                     | N/A         | \$326.52 | \$296.84    | N/A                     | N/A         |
| F                        | \$450.08 | \$409.16    | \$400.58                | \$364.16    | \$512.98 | \$466.33    | \$456.54                | \$415.04    |
| High F <sup>1</sup>      | \$129.29 | \$117.54    | N/A                     | N/A         | \$147.35 | \$133.96    | N/A                     | N/A         |
| F Plus                   | \$473.47 | \$432.55    | N/A                     | N/A         | \$536.37 | \$489.72    | N/A                     | N/A         |
| G                        | \$378.12 | \$343.74    | \$336.54                | \$305.94    | \$434.27 | \$394.77    | \$386.50                | \$351.35    |
| High G <sup>1</sup>      | \$123.12 | \$111.94    | N/A                     | N/A         | \$140.34 | \$127.58    | N/A                     | N/A         |
| G Plus                   | \$401.51 | \$367.13    | \$359.93                | \$329.33    | \$457.66 | \$418.16    | \$409.89                | \$374.74    |
| High G Plus <sup>1</sup> | \$146.51 | \$135.33    | N/A                     | N/A         | \$163.73 | \$150.97    | N/A                     | N/A         |
| N                        | \$329.12 | \$299.19    | \$292.93                | \$266.30    | \$377.98 | \$343.62    | \$336.40                | \$305.82    |
| N Plus                   | \$352.51 | \$322.58    | N/A                     | N/A         | \$401.37 | \$367.01    | N/A                     | N/A         |

# Age 82

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$293.32 | \$266.65    | N/A                     | N/A         | \$334.28 | \$303.91    | N/A                     | N/A         |
| F                        | \$460.79 | \$418.91    | \$410.11                | \$372.84    | \$525.18 | \$477.43    | \$467.40                | \$424.91    |
| High F <sup>1</sup>      | \$132.37 | \$120.33    | N/A                     | N/A         | \$150.85 | \$137.14    | N/A                     | N/A         |
| F Plus                   | \$484.18 | \$442.30    | N/A                     | N/A         | \$548.57 | \$500.82    | N/A                     | N/A         |
| G                        | \$387.68 | \$352.43    | \$345.05                | \$313.66    | \$445.16 | \$404.67    | \$396.17                | \$360.18    |
| High G <sup>1</sup>      | \$126.07 | \$114.61    | N/A                     | N/A         | \$143.67 | \$130.60    | N/A                     | N/A         |
| G Plus                   | \$411.07 | \$375.82    | \$368.44                | \$337.05    | \$468.55 | \$428.06    | \$419.56                | \$383.57    |
| High G Plus <sup>1</sup> | \$149.46 | \$138.00    | N/A                     | N/A         | \$167.06 | \$153.99    | N/A                     | N/A         |
| N                        | \$337.44 | \$306.77    | \$300.32                | \$273.03    | \$387.46 | \$352.25    | \$344.85                | \$313.49    |
| N Plus                   | \$360.83 | \$330.16    | N/A                     | N/A         | \$410.85 | \$375.64    | N/A                     | N/A         |

# Age 83

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$299.95 | \$272.68    | N/A                     | N/A         | \$341.86 | \$310.80    | N/A                     | N/A         |
| F                        | \$471.24 | \$428.41    | \$419.39                | \$381.28    | \$537.07 | \$488.24    | \$477.99                | \$434.55    |
| High F <sup>1</sup>      | \$135.37 | \$123.06    | N/A                     | N/A         | \$154.28 | \$140.26    | N/A                     | N/A         |
| F Plus                   | \$494.63 | \$451.80    | N/A                     | N/A         | \$560.46 | \$511.63    | N/A                     | N/A         |
| G                        | \$397.00 | \$360.92    | \$353.32                | \$321.20    | \$455.78 | \$414.35    | \$405.65                | \$368.76    |
| High G <sup>1</sup>      | \$128.92 | \$117.19    | N/A                     | N/A         | \$146.94 | \$133.57    | N/A                     | N/A         |
| G Plus                   | \$420.39 | \$384.31    | \$376.71                | \$344.59    | \$479.17 | \$437.74    | \$429.04                | \$392.15    |
| High G Plus <sup>1</sup> | \$152.31 | \$140.58    | N/A                     | N/A         | \$170.33 | \$156.96    | N/A                     | N/A         |
| N                        | \$345.56 | \$314.14    | \$307.56                | \$279.58    | \$396.71 | \$360.64    | \$353.06                | \$320.98    |
| N Plus                   | \$368.95 | \$337.53    | N/A                     | N/A         | \$420.10 | \$384.03    | N/A                     | N/A         |

# Age 84

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$306.44 | \$278.57    | N/A                     | N/A         | \$349.24 | \$317.48    | N/A                     | N/A         |
| F                        | \$481.40 | \$437.63    | \$428.47                | \$389.49    | \$548.66 | \$498.79    | \$488.30                | \$443.92    |
| High F <sup>1</sup>      | \$138.28 | \$125.73    | N/A                     | N/A         | \$157.61 | \$143.28    | N/A                     | N/A         |
| F Plus                   | \$504.79 | \$461.02    | N/A                     | N/A         | \$572.05 | \$522.18    | N/A                     | N/A         |
| G                        | \$406.08 | \$369.17    | \$361.41                | \$328.56    | \$466.13 | \$423.75    | \$414.85                | \$377.15    |
| High G <sup>1</sup>      | \$131.71 | \$119.74    | N/A                     | N/A         | \$150.12 | \$136.45    | N/A                     | N/A         |
| G Plus                   | \$429.47 | \$392.56    | \$384.80                | \$351.95    | \$489.52 | \$447.14    | \$438.24                | \$400.54    |
| High G Plus <sup>1</sup> | \$155.10 | \$143.13    | N/A                     | N/A         | \$173.51 | \$159.84    | N/A                     | N/A         |
| N                        | \$353.47 | \$321.34    | \$314.59                | \$285.98    | \$405.73 | \$368.84    | \$361.09                | \$328.26    |
| N Plus                   | 376.86   | 344.73      | N/A                     | N/A         | \$429.12 | \$392.23    | N/A                     | N/A         |

# Age 85

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$312.72 | \$284.32    | N/A                     | N/A         | \$356.42 | \$324.03    | N/A                     | N/A         |
| F                        | \$491.31 | \$446.66    | \$437.26                | \$397.51    | \$559.94 | \$509.05    | \$498.35                | \$453.05    |
| High F <sup>1</sup>      | \$141.13 | \$128.31    | N/A                     | N/A         | \$160.86 | \$146.22    | N/A                     | N/A         |
| F Plus                   | \$514.70 | \$470.05    | N/A                     | N/A         | \$583.33 | \$532.44    | N/A                     | N/A         |
| G                        | \$414.94 | \$377.21    | \$369.28                | \$335.72    | \$476.20 | \$432.91    | \$423.82                | \$385.29    |
| High G <sup>1</sup>      | \$134.40 | \$122.19    | N/A                     | N/A         | \$153.19 | \$139.26    | N/A                     | N/A         |
| G Plus                   | \$438.33 | \$400.60    | \$392.67                | \$359.11    | \$499.59 | \$456.30    | \$447.21                | \$408.68    |
| High G Plus <sup>1</sup> | \$157.79 | \$145.58    | N/A                     | N/A         | \$176.58 | \$162.65    | N/A                     | N/A         |
| N                        | \$361.15 | \$328.32    | \$321.43                | \$292.20    | \$414.49 | \$376.83    | \$368.90                | \$335.38    |
| N Plus                   | \$384.54 | \$351.71    | N/A                     | N/A         | \$437.88 | \$400.22    | N/A                     | N/A         |

# Age 86

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$318.87 | \$289.87    | N/A                     | N/A         | \$363.43 | \$330.38    | N/A                     | N/A         |
| F                        | \$500.95 | \$455.39    | \$445.83                | \$405.32    | \$570.94 | \$519.02    | \$508.14                | \$461.94    |
| High F <sup>1</sup>      | \$143.91 | \$130.82    | N/A                     | N/A         | \$164.00 | \$149.09    | N/A                     | N/A         |
| F Plus                   | \$524.34 | \$478.78    | N/A                     | N/A         | \$594.33 | \$542.41    | N/A                     | N/A         |
| G                        | \$423.52 | \$385.02    | \$376.92                | \$342.67    | \$486.00 | \$441.81    | \$432.54                | \$393.22    |
| High G <sup>1</sup>      | \$137.05 | \$124.61    | N/A                     | N/A         | \$156.19 | \$142.00    | N/A                     | N/A         |
| G Plus                   | \$446.91 | \$408.41    | \$400.31                | \$366.06    | \$509.39 | \$465.20    | \$455.93                | \$416.61    |
| High G Plus <sup>1</sup> | \$160.44 | \$148.00    | N/A                     | N/A         | \$179.58 | \$165.39    | N/A                     | N/A         |
| N                        | \$368.65 | \$335.13    | \$328.09                | \$298.27    | \$423.02 | \$384.56    | \$376.50                | \$342.26    |
| N Plus                   | \$392.04 | \$358.52    | N/A                     | N/A         | \$446.41 | \$407.95    | N/A                     | N/A         |

# Age 87

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$324.83 | \$295.30    | N/A                     | N/A         | \$370.20 | \$336.56    | N/A                     | N/A         |
| F                        | \$510.33 | \$463.94    | \$454.17                | \$412.89    | \$581.61 | \$528.73    | \$517.62                | \$470.57    |
| High F <sup>1</sup>      | \$146.60 | \$133.27    | N/A                     | N/A         | \$167.05 | \$151.89    | N/A                     | N/A         |
| F Plus                   | \$533.72 | \$487.33    | N/A                     | N/A         | \$605.00 | \$552.12    | N/A                     | N/A         |
| G                        | \$431.89 | \$392.63    | \$384.38                | \$349.44    | \$495.54 | \$450.49    | \$441.03                | \$400.95    |
| High G <sup>1</sup>      | \$139.62 | \$126.92    | N/A                     | N/A         | \$159.11 | \$144.65    | N/A                     | N/A         |
| G Plus                   | \$455.28 | \$416.02    | \$407.77                | \$372.83    | \$518.93 | \$473.88    | \$464.42                | \$424.34    |
| High G Plus <sup>1</sup> | \$163.01 | \$150.31    | N/A                     | N/A         | \$182.50 | \$168.04    | N/A                     | N/A         |
| N                        | \$375.92 | \$341.74    | \$334.58                | \$304.16    | \$431.33 | \$392.12    | \$383.88                | \$348.97    |
| N Plus                   | \$399.31 | \$365.13    | N/A                     | N/A         | \$454.72 | \$415.51    | N/A                     | N/A         |

# Age 88

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$330.62 | \$300.56    | N/A                     | N/A         | \$376.81 | \$342.57    | N/A                     | N/A         |
| F                        | \$519.41 | \$472.19    | \$462.28                | \$420.26    | \$591.97 | \$538.15    | \$526.86                | \$478.95    |
| High F <sup>1</sup>      | \$149.20 | \$135.64    | N/A                     | N/A         | \$170.04 | \$154.58    | N/A                     | N/A         |
| F Plus                   | \$542.80 | \$495.58    | N/A                     | N/A         | \$615.36 | \$561.54    | N/A                     | N/A         |
| G                        | \$440.01 | \$400.02    | \$391.62                | \$356.01    | \$504.79 | \$458.91    | \$449.25                | \$408.42    |
| High G <sup>1</sup>      | \$142.09 | \$129.19    | N/A                     | N/A         | \$161.95 | \$147.23    | N/A                     | N/A         |
| G Plus                   | \$463.40 | \$423.41    | \$415.01                | \$379.40    | \$528.18 | \$482.30    | \$472.64                | \$431.81    |
| High G Plus <sup>1</sup> | \$165.48 | \$152.58    | N/A                     | N/A         | \$185.34 | \$170.62    | N/A                     | N/A         |
| N                        | \$382.99 | \$348.17    | \$340.86                | \$309.88    | \$439.37 | \$399.44    | \$391.05                | \$355.50    |
| N Plus                   | \$406.38 | \$371.56    | N/A                     | N/A         | \$462.76 | \$422.83    | N/A                     | N/A         |

# Age 89

|                                | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                                | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                                | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| <b>A</b>                       | \$336.25 | \$305.67    | N/A                     | N/A         | \$383.22 | \$348.38    | N/A                     | N/A         |
| <b>F</b>                       | \$528.25 | \$480.23    | \$470.15                | \$427.38    | \$602.04 | \$547.31    | \$535.83                | \$487.12    |
| <b>High F<sup>1</sup></b>      | \$151.74 | \$137.95    | N/A                     | N/A         | \$172.93 | \$157.23    | N/A                     | N/A         |
| <b>F Plus</b>                  | \$551.64 | \$503.62    | N/A                     | N/A         | \$625.43 | \$570.70    | N/A                     | N/A         |
| <b>G</b>                       | \$447.90 | \$407.19    | \$398.64                | \$362.39    | \$513.78 | \$467.06    | \$457.27                | \$415.70    |
| <b>High G<sup>1</sup></b>      | \$144.51 | \$131.38    | N/A                     | N/A         | \$164.71 | \$149.73    | N/A                     | N/A         |
| <b>G Plus</b>                  | \$471.29 | \$430.58    | \$422.03                | \$385.78    | \$537.17 | \$490.45    | \$480.66                | \$439.09    |
| <b>High G Plus<sup>1</sup></b> | \$167.90 | \$154.77    | N/A                     | N/A         | \$188.10 | \$173.12    | N/A                     | N/A         |
| <b>N</b>                       | \$389.86 | \$354.42    | \$346.98                | \$315.42    | \$447.21 | \$406.55    | \$398.00                | \$361.83    |
| <b>N Plus</b>                  | \$413.25 | \$377.81    | N/A                     | N/A         | \$470.60 | \$429.94    | N/A                     | N/A         |

# Age 90

|                                | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                                | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                                | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| <b>A</b>                       | \$341.69 | \$310.62    | N/A                     | N/A         | \$389.45 | \$354.03    | N/A                     | N/A         |
| <b>F</b>                       | \$536.81 | \$488.00    | \$477.76                | \$434.32    | \$611.81 | \$556.19    | \$544.52                | \$495.00    |
| <b>High F<sup>1</sup></b>      | \$154.21 | \$140.17    | N/A                     | N/A         | \$175.74 | \$159.77    | N/A                     | N/A         |
| <b>F Plus</b>                  | \$560.20 | \$511.39    | N/A                     | N/A         | \$635.20 | \$579.58    | N/A                     | N/A         |
| <b>G</b>                       | \$455.56 | \$414.13    | \$405.44                | \$368.58    | \$522.51 | \$475.01    | \$465.02                | \$422.76    |
| <b>High G<sup>1</sup></b>      | \$146.87 | \$133.52    | N/A                     | N/A         | \$167.39 | \$152.17    | N/A                     | N/A         |
| <b>G Plus</b>                  | \$478.95 | \$437.52    | \$428.83                | \$391.97    | \$545.90 | \$498.40    | \$488.41                | \$446.15    |
| <b>High G Plus<sup>1</sup></b> | \$170.26 | \$156.91    | N/A                     | N/A         | \$190.78 | \$175.56    | N/A                     | N/A         |
| <b>N</b>                       | \$396.52 | \$360.47    | \$352.91                | \$320.81    | \$454.78 | \$413.45    | \$404.74                | \$367.95    |
| <b>N Plus</b>                  | \$419.91 | \$383.86    | N/A                     | N/A         | \$478.17 | \$436.84    | N/A                     | N/A         |

# Age 91

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$346.98 | \$315.44    | N/A                     | N/A         | \$395.46 | \$359.51    | N/A                     | N/A         |
| F                        | \$545.12 | \$495.54    | \$485.15                | \$441.04    | \$621.25 | \$564.77    | \$552.93                | \$502.66    |
| High F <sup>1</sup>      | \$156.59 | \$142.36    | N/A                     | N/A         | \$178.47 | \$162.25    | N/A                     | N/A         |
| F Plus                   | \$568.51 | \$518.93    | N/A                     | N/A         | \$644.64 | \$588.16    | N/A                     | N/A         |
| G                        | \$462.95 | \$420.87    | \$412.04                | \$374.58    | \$530.94 | \$482.66    | \$472.54                | \$429.58    |
| High G <sup>1</sup>      | \$149.13 | \$135.58    | N/A                     | N/A         | \$169.96 | \$154.52    | N/A                     | N/A         |
| G Plus                   | \$486.34 | \$444.26    | \$435.43                | \$397.97    | \$554.33 | \$506.05    | \$495.93                | \$452.97    |
| High G Plus <sup>1</sup> | \$172.52 | \$158.97    | N/A                     | N/A         | \$193.35 | \$177.91    | N/A                     | N/A         |
| N                        | \$402.96 | \$366.33    | \$358.63                | \$326.01    | \$462.12 | \$420.13    | \$411.30                | \$373.92    |
| N Plus                   | \$426.35 | \$389.72    | N/A                     | N/A         | \$485.51 | \$443.52    | N/A                     | N/A         |

# Age 92

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$352.08 | \$320.09    | N/A                     | N/A         | \$401.27 | \$364.81    | N/A                     | N/A         |
| F                        | \$553.13 | \$502.85    | \$492.29                | \$447.54    | \$630.41 | \$573.11    | \$561.07                | \$510.05    |
| High F <sup>1</sup>      | \$158.90 | \$144.45    | N/A                     | N/A         | \$181.10 | \$164.64    | N/A                     | N/A         |
| F Plus                   | \$576.52 | \$526.24    | N/A                     | N/A         | \$653.80 | \$596.50    | N/A                     | N/A         |
| G                        | \$470.12 | \$427.38    | \$418.40                | \$380.37    | \$539.11 | \$490.10    | \$479.81                | \$436.18    |
| High G <sup>1</sup>      | \$151.32 | \$137.59    | N/A                     | N/A         | \$172.47 | \$156.79    | N/A                     | N/A         |
| G Plus                   | \$493.51 | \$450.77    | \$441.79                | \$403.76    | \$562.50 | \$513.49    | \$503.20                | \$459.57    |
| High G Plus <sup>1</sup> | \$174.71 | \$160.98    | N/A                     | N/A         | \$195.86 | \$180.18    | N/A                     | N/A         |
| N                        | \$409.19 | \$372.01    | \$364.19                | \$331.07    | \$469.25 | \$426.58    | \$417.63                | \$379.66    |
| N Plus                   | \$432.58 | \$395.40    | N/A                     | N/A         | \$492.64 | \$449.97    | N/A                     | N/A         |

# Age 93

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$357.02 | \$324.58    | N/A                     | N/A         | \$406.90 | \$369.90    | N/A                     | N/A         |
| F                        | \$560.89 | \$509.90    | \$499.21                | \$453.82    | \$639.26 | \$581.14    | \$568.96                | \$517.21    |
| High F <sup>1</sup>      | \$161.12 | \$146.46    | N/A                     | N/A         | \$183.64 | \$166.94    | N/A                     | N/A         |
| F Plus                   | \$584.28 | \$533.29    | N/A                     | N/A         | \$662.65 | \$604.53    | N/A                     | N/A         |
| G                        | \$477.06 | \$433.70    | \$424.58                | \$385.98    | \$547.01 | \$497.27    | \$486.83                | \$442.57    |
| High G <sup>1</sup>      | \$153.46 | \$139.50    | N/A                     | N/A         | \$174.89 | \$158.99    | N/A                     | N/A         |
| G Plus                   | \$500.45 | \$457.09    | \$447.97                | \$409.37    | \$570.40 | \$520.66    | \$510.22                | \$465.96    |
| High G Plus <sup>1</sup> | \$176.85 | \$162.89    | N/A                     | N/A         | \$198.28 | \$182.38    | N/A                     | N/A         |
| N                        | \$415.24 | \$377.48    | \$369.54                | \$335.96    | \$476.12 | \$432.83    | \$423.75                | \$385.23    |
| N Plus                   | \$438.63 | \$400.87    | N/A                     | N/A         | \$499.51 | \$456.22    | N/A                     | N/A         |

# Age 94

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$361.79 | \$328.91    | N/A                     | N/A         | \$412.35 | \$374.85    | N/A                     | N/A         |
| F                        | \$568.40 | \$516.71    | \$505.86                | \$459.88    | \$647.79 | \$588.91    | \$576.54                | \$524.12    |
| High F <sup>1</sup>      | \$163.28 | \$148.43    | N/A                     | N/A         | \$186.10 | \$169.16    | N/A                     | N/A         |
| F Plus                   | \$591.79 | \$540.10    | N/A                     | N/A         | \$671.18 | \$612.30    | N/A                     | N/A         |
| G                        | \$483.74 | \$439.76    | \$430.52                | \$391.39    | \$554.62 | \$504.21    | \$493.61                | \$448.74    |
| High G <sup>1</sup>      | \$155.50 | \$141.37    | N/A                     | N/A         | \$177.24 | \$161.11    | N/A                     | N/A         |
| G Plus                   | \$507.13 | \$463.15    | \$453.91                | \$414.78    | \$578.01 | \$527.60    | \$517.00                | \$472.13    |
| High G Plus <sup>1</sup> | \$178.89 | \$164.76    | N/A                     | N/A         | \$200.63 | \$184.50    | N/A                     | N/A         |
| N                        | \$421.06 | \$382.78    | \$374.74                | \$340.65    | \$482.76 | \$438.87    | \$429.64                | \$390.59    |
| N Plus                   | \$444.45 | \$406.17    | N/A                     | N/A         | \$506.15 | \$462.26    | N/A                     | N/A         |

# Age 95

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$366.41 | \$333.09    | N/A                     | N/A         | \$417.57 | \$379.62    | N/A                     | N/A         |
| F                        | \$575.63 | \$523.30    | \$512.29                | \$465.73    | \$656.03 | \$596.38    | \$583.87                | \$530.78    |
| High F <sup>1</sup>      | \$165.35 | \$150.31    | N/A                     | N/A         | \$188.44 | \$171.32    | N/A                     | N/A         |
| F Plus                   | \$599.02 | \$546.69    | N/A                     | N/A         | \$679.42 | \$619.77    | N/A                     | N/A         |
| G                        | \$490.18 | \$445.62    | \$436.27                | \$396.62    | \$561.98 | \$510.89    | \$500.16                | \$454.69    |
| High G <sup>1</sup>      | \$157.48 | \$143.16    | N/A                     | N/A         | \$179.48 | \$163.17    | N/A                     | N/A         |
| G Plus                   | \$513.57 | \$469.01    | \$459.66                | \$420.01    | \$585.37 | \$534.28    | \$523.55                | \$478.08    |
| High G Plus <sup>1</sup> | \$180.87 | \$166.55    | N/A                     | N/A         | \$202.87 | \$186.56    | N/A                     | N/A         |
| N                        | \$426.66 | \$387.87    | \$379.73                | \$345.22    | \$489.15 | \$444.68    | \$435.34                | \$395.77    |
| N Plus                   | \$450.05 | \$411.26    | N/A                     | N/A         | \$512.54 | \$468.07    | N/A                     | N/A         |

# Age 96

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$370.83 | \$337.12    | N/A                     | N/A         | \$422.63 | \$384.23    | N/A                     | N/A         |
| F                        | \$582.56 | \$529.61    | \$518.49                | \$471.34    | \$663.95 | \$603.58    | \$590.92                | \$537.20    |
| High F <sup>1</sup>      | \$167.34 | \$152.16    | N/A                     | N/A         | \$190.74 | \$173.37    | N/A                     | N/A         |
| F Plus                   | \$605.95 | \$553.00    | N/A                     | N/A         | \$687.34 | \$626.97    | N/A                     | N/A         |
| G                        | \$496.40 | \$451.27    | \$441.79                | \$401.64    | \$569.05 | \$517.33    | \$506.46                | \$460.42    |
| High G <sup>1</sup>      | \$159.38 | \$144.90    | N/A                     | N/A         | \$181.64 | \$165.11    | N/A                     | N/A         |
| G Plus                   | \$519.79 | \$474.66    | \$465.18                | \$425.03    | \$592.44 | \$540.72    | \$529.85                | \$483.81    |
| High G Plus <sup>1</sup> | \$182.77 | \$168.29    | N/A                     | N/A         | \$205.03 | \$188.50    | N/A                     | N/A         |
| N                        | \$432.05 | \$392.80    | \$384.54                | \$349.57    | \$495.30 | \$450.28    | \$440.84                | \$400.76    |
| N Plus                   | \$455.44 | \$416.19    | N/A                     | N/A         | \$518.69 | \$473.67    | N/A                     | N/A         |

# Age 97

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$375.07 | \$340.98    | N/A                     | N/A         | \$427.47 | \$388.62    | N/A                     | N/A         |
| F                        | \$589.27 | \$535.70    | \$524.44                | \$476.75    | \$671.57 | \$610.53    | \$597.70                | \$543.37    |
| High F <sup>1</sup>      | \$169.27 | \$153.89    | N/A                     | N/A         | \$192.92 | \$175.38    | N/A                     | N/A         |
| F Plus                   | \$612.66 | \$559.09    | N/A                     | N/A         | \$694.96 | \$633.92    | N/A                     | N/A         |
| G                        | \$502.38 | \$456.70    | \$447.11                | \$406.46    | \$575.86 | \$523.50    | \$512.51                | \$465.91    |
| High G <sup>1</sup>      | \$161.21 | \$146.57    | N/A                     | N/A         | \$183.72 | \$167.03    | N/A                     | N/A         |
| G Plus                   | \$525.77 | \$480.09    | \$470.50                | \$429.85    | \$599.25 | \$546.89    | \$535.90                | \$489.30    |
| High G Plus <sup>1</sup> | \$184.60 | \$169.96    | N/A                     | N/A         | \$207.11 | \$190.42    | N/A                     | N/A         |
| N                        | \$437.27 | \$397.52    | \$389.17                | \$353.79    | \$501.23 | \$455.66    | \$446.10                | \$405.54    |
| N Plus                   | \$460.66 | \$420.91    | N/A                     | N/A         | \$524.62 | \$479.05    | N/A                     | N/A         |

# Age 98

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$379.16 | \$344.69    | N/A                     | N/A         | \$432.12 | \$392.86    | N/A                     | N/A         |
| F                        | \$595.69 | \$541.52    | \$530.14                | \$481.97    | \$678.89 | \$617.18    | \$604.22                | \$549.28    |
| High F <sup>1</sup>      | \$171.10 | \$155.54    | N/A                     | N/A         | \$195.01 | \$177.29    | N/A                     | N/A         |
| F Plus                   | \$619.08 | \$564.91    | N/A                     | N/A         | \$702.28 | \$640.57    | N/A                     | N/A         |
| G                        | \$508.09 | \$461.91    | \$452.20                | \$411.09    | \$582.40 | \$529.45    | \$518.32                | \$471.22    |
| High G <sup>1</sup>      | \$162.96 | \$148.16    | N/A                     | N/A         | \$185.74 | \$168.85    | N/A                     | N/A         |
| G Plus                   | \$531.48 | \$485.30    | \$475.59                | \$434.48    | \$605.79 | \$552.84    | \$541.71                | \$494.61    |
| High G Plus <sup>1</sup> | \$186.35 | \$171.55    | N/A                     | N/A         | \$209.13 | \$192.24    | N/A                     | N/A         |
| N                        | \$442.26 | \$402.07    | \$393.60                | \$357.81    | \$506.94 | \$460.84    | \$451.15                | \$410.13    |
| N Plus                   | \$465.65 | \$425.46    | N/A                     | N/A         | \$530.33 | \$484.23    | N/A                     | N/A         |

# Age 99

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$383.09 | \$348.26    | N/A                     | N/A         | \$436.61 | \$396.92    | N/A                     | N/A         |
| F                        | \$601.83 | \$547.11    | \$535.63                | \$486.93    | \$685.91 | \$623.55    | \$610.46                | \$554.97    |
| High F <sup>1</sup>      | \$172.89 | \$157.17    | N/A                     | N/A         | \$197.04 | \$179.12    | N/A                     | N/A         |
| F Plus                   | \$625.22 | \$570.50    | N/A                     | N/A         | \$709.30 | \$646.94    | N/A                     | N/A         |
| G                        | \$513.59 | \$466.90    | \$457.10                | \$415.55    | \$588.66 | \$535.14    | \$523.90                | \$476.27    |
| High G <sup>1</sup>      | \$164.65 | \$149.69    | N/A                     | N/A         | \$187.65 | \$170.59    | N/A                     | N/A         |
| G Plus                   | \$536.98 | \$490.29    | \$480.49                | \$438.94    | \$612.05 | \$558.53    | \$547.29                | \$499.66    |
| High G Plus <sup>1</sup> | \$188.04 | \$173.08    | N/A                     | N/A         | \$211.04 | \$193.98    | N/A                     | N/A         |
| N                        | \$447.05 | \$406.41    | \$397.88                | \$361.69    | \$512.37 | \$465.79    | \$456.02                | \$414.55    |
| N Plus                   | \$470.44 | \$429.80    | N/A                     | N/A         | \$535.76 | \$489.18    | N/A                     | N/A         |

# Age 100 +

|                          | FEMALE   |             |                         |             | MALE     |             |                         |             |
|--------------------------|----------|-------------|-------------------------|-------------|----------|-------------|-------------------------|-------------|
|                          | Standard |             | Med-Select <sup>4</sup> |             | Standard |             | Med-Select <sup>4</sup> |             |
|                          | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco | Tobacco  | Non-Tobacco | Tobacco                 | Non-Tobacco |
| A                        | \$386.84 | \$351.68    | N/A                     | N/A         | \$440.87 | \$400.78    | N/A                     | N/A         |
| F                        | \$607.74 | \$552.48    | \$540.87                | \$491.71    | \$692.61 | \$629.66    | \$616.42                | \$560.38    |
| High F <sup>1</sup>      | \$174.59 | \$158.70    | N/A                     | N/A         | \$198.95 | \$180.87    | N/A                     | N/A         |
| F Plus                   | \$631.13 | \$575.87    | N/A                     | N/A         | \$716.00 | \$653.05    | N/A                     | N/A         |
| G                        | \$518.85 | \$471.68    | \$461.78                | \$419.80    | \$594.63 | \$540.59    | \$529.23                | \$481.13    |
| High G <sup>1</sup>      | \$166.27 | \$151.14    | N/A                     | N/A         | \$189.49 | \$172.25    | N/A                     | N/A         |
| G Plus                   | \$542.24 | \$495.07    | \$485.17                | \$443.19    | \$618.02 | \$563.98    | \$552.62                | \$504.52    |
| High G Plus <sup>1</sup> | \$189.66 | \$174.53    | N/A                     | N/A         | \$212.88 | \$195.64    | N/A                     | N/A         |
| N                        | \$451.61 | \$410.57    | \$401.93                | \$365.39    | \$517.58 | \$470.54    | \$460.65                | \$418.77    |
| N Plus                   | \$475.00 | \$433.96    | N/A                     | N/A         | \$540.97 | \$493.93    | N/A                     | N/A         |

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, High Deductible Plan F<sup>1</sup>, Plan F Plus, High Deductible Plan G<sup>1</sup>, High Deductible Plan G Plus<sup>1</sup>, and Plan 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<sup>SM</sup> 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<sup>SM</sup>**

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<sup>SM</sup> 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

Review the application carefully before you sign it. Be certain that all information is 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: HCSC only offers the Medicare Select option on Plans F, G, G Plus, and N.

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                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------|--------------------------------|
| <b>Hospitalization<sup>5</sup></b><br>Semiprivate room and board, general nursing, and miscellaneous services and supplies                                                                                                            |                                                                                            |                                    |                                |
| First 60 days                                                                                                                                                                                                                         | All but \$1,676                                                                            | \$0                                | \$1,676<br>(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 <sup>6</sup>               |
| Beyond the additional 365 days                                                                                                                                                                                                        | \$0                                                                                        | \$0                                | All costs                      |
| <b>Skilled Nursing Facility Care<sup>5</sup></b><br>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                      |
| <b>Blood</b>                                                                                                                                                                                                                          |                                                                                            |                                    |                                |
| First 3 pints                                                                                                                                                                                                                         | \$0                                                                                        | 3 pints                            | \$0                            |
| Additional amounts                                                                                                                                                                                                                    | 100%                                                                                       | \$0                                | \$0                            |
| <b>Hospice Care</b><br>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 \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                               | \$0           | \$0           | \$257 (Part B deductible) |
| Remainder of Medicare-approved amounts                                                                                                                                                                                                                              | Generally 80% | Generally 20% | \$0                       |
| <b>Part B Excess Charges</b><br>(above Medicare-approved amounts)                                                                                                                                                                                                   | \$0           | \$0           | All costs                 |
| <b>Blood</b>                                                                                                                                                                                                                                                        |               |               |                           |
| First 3 pints                                                                                                                                                                                                                                                       | \$0           | All costs     | \$0                       |
| Next \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                                | \$0           | \$0           | \$257 (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 \$257 of Medicare-approved amounts <sup>7</sup>        | \$0           | \$0         | \$257 (Part B deductible) |
| – Remainder of Medicare-approved amounts                       | 80%           | 20%         | \$0                       |

<sup>7</sup> 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          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------|------------------|
| <b>Hospitalization<sup>5</sup></b><br>Semiprivate room and board, general nursing, and miscellaneous services and supplies                                                                                                            |                                                                                            |                                    |                  |
| First 60 days                                                                                                                                                                                                                         | All but \$1,676                                                                            | \$1,676<br>(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 <sup>6</sup> |
| Beyond the additional 365 days                                                                                                                                                                                                        | \$0                                                                                        | \$0                                | All costs        |
| <b>Skilled Nursing Facility Care<sup>5</sup></b><br>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        |
| <b>Blood</b>                                                                                                                                                                                                                          |                                                                                            |                                    |                  |
| First 3 pints                                                                                                                                                                                                                         | \$0                                                                                        | 3 pints                            | \$0              |
| Additional amounts                                                                                                                                                                                                                    | 100%                                                                                       | \$0                                | \$0              |
| <b>Hospice Care</b><br>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 \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                               | \$0           | \$257 (Part B deductible) | \$0     |
| Remainder of Medicare-approved amounts                                                                                                                                                                                                                              | Generally 80% | Generally 20%             | \$0     |
| <b>Part B Excess Charges</b><br>(above Medicare-approved amounts)                                                                                                                                                                                                   | \$0           | 100%                      | \$0     |
| <b>Blood</b>                                                                                                                                                                                                                                                        |               |                           |         |
| First 3 pints                                                                                                                                                                                                                                                       | \$0           | All costs                 | \$0     |
| Next \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                                | \$0           | \$257 (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 \$257 of Medicare-approved amounts <sup>7</sup>        | \$0           | \$257 (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><br>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 |

# High Deductible Plan F

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

| Services                                                                                                                                                                                                                                          | Medicare Pays                                                                                              | After You Pay<br>\$2,870 Deductible <sup>1</sup> ,<br>Plan F Pays | In Addition to<br>\$2,870 Deductible <sup>1</sup> ,<br>You Pay |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------|
| <b>Hospitalization<sup>5</sup></b><br>Semiprivate room and board, general nursing,<br>and miscellaneous services and supplies                                                                                                                     |                                                                                                            |                                                                   |                                                                |
| First 60 days                                                                                                                                                                                                                                     | All but \$1,676                                                                                            | \$1,676<br>(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<br>Reserve days are used                                                                                                                                                                                      | \$0                                                                                                        | 100% of Medicare-<br>eligible expenses                            | \$0 <sup>6</sup>                                               |
| Beyond the additional 365 days                                                                                                                                                                                                                    | \$0                                                                                                        | \$0                                                               | All costs                                                      |
| <b>Skilled Nursing Facility Care<sup>5</sup></b><br>You must meet Medicare's requirements,<br>including having been in a hospital for at least<br>3 days and entered a Medicare-approved<br>facility within 30 days after leaving the<br>hospital |                                                                                                            |                                                                   |                                                                |
| First 20 days                                                                                                                                                                                                                                     | All approved<br>amounts                                                                                    | \$0                                                               | \$0                                                            |
| 21st through 100th day                                                                                                                                                                                                                            | All but \$209.50<br>a day                                                                                  | Up to \$209.50 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><br>You must meet Medicare's requirements,<br>including a doctor's certification of<br>terminal illness                                                                                                                        | All but very limited<br>copayment/<br>coinsurance for<br>outpatient drugs<br>and inpatient<br>respite care | Medicare copayment/<br>coinsurance                                | \$0                                                            |

# High Deductible Plan F

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

| Services                                                                                                                                                                                                                                                            | Medicare Pays | After You Pay \$2,870 Deductible <sup>1</sup> , Plan F Pays | In Addition to \$2,870 Deductible <sup>1</sup> , 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 \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                               | \$0           | \$257 (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 \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                                | \$0           | \$257 (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 | After You Pay \$2,870 Deductible <sup>1</sup> , Plan F Pays | In Addition to \$2,870 Deductible <sup>1</sup> , 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 \$257 of Medicare-approved amounts <sup>7</sup>        | \$0           | \$257 (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 F Plus

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

| Services                                                                                                                                                                                                                              | Medicare Pays                                                                              | Plan F Plus Pays                   | You Pay          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------|------------------|
| <b>Hospitalization<sup>5</sup></b><br>Semiprivate room and board, general nursing, and miscellaneous services and supplies                                                                                                            |                                                                                            |                                    |                  |
| First 60 days                                                                                                                                                                                                                         | All but \$1,676                                                                            | \$1,676<br>(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 <sup>6</sup> |
| Beyond the additional 365 days                                                                                                                                                                                                        | \$0                                                                                        | \$0                                | All costs        |
| <b>Skilled Nursing Facility Care<sup>5</sup></b><br>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        |
| <b>Blood</b>                                                                                                                                                                                                                          |                                                                                            |                                    |                  |
| First 3 pints                                                                                                                                                                                                                         | \$0                                                                                        | 3 pints                            | \$0              |
| Additional amounts                                                                                                                                                                                                                    | 100%                                                                                       | \$0                                | \$0              |
| <b>Hospice Care</b><br>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 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------|---------|
| <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 \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                               | \$0           | \$257 (Part B deductible) | \$0     |
| Remainder of Medicare-approved amounts                                                                                                                                                                                                                              | Generally 80% | Generally 20%             | \$0     |
| <b>Part B Excess Charges</b><br>(above Medicare-approved amounts)                                                                                                                                                                                                   | \$0           | 100%                      | \$0     |
| <b>Blood</b>                                                                                                                                                                                                                                                        |               |                           |         |
| First 3 pints                                                                                                                                                                                                                                                       | \$0           | All costs                 | \$0     |
| Next \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                                | \$0           | \$257 (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 Plus 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 \$257 of Medicare-approved amounts <sup>7</sup>        | \$0           | \$257 (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><br>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 |
|-----------------------------------------------|---------------|------------------|---------|
| <b>Diagnostic Evaluations</b>                 |               |                  |         |
| In Network                                    | \$0           | 100%             | \$0     |
| Out of Network                                | \$0           | 50%              | 50%     |
| <b>Preventive Services</b>                    |               |                  |         |
| In Network                                    | \$0           | 100%             | \$0     |
| Out of Network                                | \$0           | 50%              | 50%     |
| <b>Diagnostic Radiographs</b>                 |               |                  |         |
| In Network                                    | \$0           | 100%             | \$0     |
| Out of Network                                | \$0           | 50%              | 50%     |
| <b>Basic Restorative Services<sup>8</sup></b> | \$0           | 50%              | 50%     |
| <b>Non-Surgical Extractions</b>               |               |                  |         |
| In Network                                    | \$0           | 75%              | 25%     |
| Out of Network                                | \$0           | 50%              | 50%     |

### VISION

| Services                          | Medicare Pays | Plan F Plus Pays | You Pay           |
|-----------------------------------|---------------|------------------|-------------------|
| <b>Annual Routine Examination</b> |               |                  |                   |
| In Network                        | \$0           | 100%             | \$0               |
| Out of Network                    | \$0           | All except \$40  | \$40              |
| <b>Materials Allowance</b>        |               |                  |                   |
| In Network                        | \$0           | \$130            | Remaining Balance |
| Out of Network                    | \$0           | \$65             | Remaining Balance |

### HEARING<sup>9</sup>

| Services                          | Medicare Pays | Plan F Plus Pays | You Pay           |
|-----------------------------------|---------------|------------------|-------------------|
| <b>Annual Routine Examination</b> | \$0           | 100%             | \$0               |
| <b>Hardware Discounts</b>         | \$0           | Generally 30%    | Remaining Balance |

<sup>8</sup> Once per tooth per calendar year.

<sup>9</sup> 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          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------|------------------|
| <b>Hospitalization<sup>5</sup></b><br>Semiprivate room and board, general nursing, and miscellaneous services and supplies                                                                                                            |                                                                                            |                                    |                  |
| First 60 days                                                                                                                                                                                                                         | All but \$1,676                                                                            | \$1,676<br>(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 <sup>6</sup> |
| Beyond the additional 365 days                                                                                                                                                                                                        | \$0                                                                                        | \$0                                | All costs        |
| <b>Skilled Nursing Facility Care<sup>5</sup></b><br>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        |
| <b>Blood</b>                                                                                                                                                                                                                          |                                                                                            |                                    |                  |
| First 3 pints                                                                                                                                                                                                                         | \$0                                                                                        | 3 pints                            | \$0              |
| Additional amounts                                                                                                                                                                                                                    | 100%                                                                                       | \$0                                | \$0              |
| <b>Hospice Care</b><br>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 \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                               | \$0           | \$0           | \$257 (Part B deductible) |
| Remainder of Medicare-approved amounts                                                                                                                                                                                                                              | Generally 80% | Generally 20% | \$0                       |
| <b>Part B Excess Charges</b><br>(above Medicare-approved amounts)                                                                                                                                                                                                   | \$0           | 100%          | \$0                       |
| <b>Blood</b>                                                                                                                                                                                                                                                        |               |               |                           |
| First 3 pints                                                                                                                                                                                                                                                       | \$0           | All costs     | \$0                       |
| Next \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                                | \$0           | \$0           | \$257 (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 G Pays | You Pay                   |
|----------------------------------------------------------------|---------------|-------------|---------------------------|
| Medically necessary skilled care services and medical supplies | 100%          | \$0         | \$0                       |
| Durable medical equipment                                      |               |             |                           |
| – First \$257 of Medicare-approved amounts <sup>7</sup>        | \$0           | \$0         | \$257 (Part B deductible) |
| – Remainder of Medicare-approved amounts                       | 80%           | 20%         | \$0                       |

## OTHER BENEFITS – NOT COVERED BY MEDICARE

|                                                                                                                                                                |     |                                               |                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----------------------------------------------|----------------------------------------------------|
| <b>Foreign Travel — Not Covered by Medicare</b><br>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 |

# High Deductible Plan G

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

| Services                                                                                                                                                                                                                                       | Medicare Pays                                                                                           | After You Pay<br>\$2,870 Deductible <sup>1</sup> ,<br>Plan G Pays | In Addition<br>to \$2,870<br>Deductible <sup>1</sup> ,<br>You Pay |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------|
| <b>Hospitalization<sup>5</sup></b><br>Semiprivate room and board, general nursing,<br>and miscellaneous services and supplies                                                                                                                  |                                                                                                         |                                                                   |                                                                   |
| First 60 days                                                                                                                                                                                                                                  | All but \$1,676                                                                                         | \$1,676<br>(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<br>days are used                                                                                                                                                                                   | \$0                                                                                                     | 100% of Medicare-<br>eligible expenses                            | \$0 <sup>6</sup>                                                  |
| Beyond the additional 365 days                                                                                                                                                                                                                 | \$0                                                                                                     | \$0                                                               | All costs                                                         |
| <b>Skilled Nursing Facility Care<sup>5</sup></b><br>You must meet Medicare's requirements,<br>including having been in a hospital for at least<br>3 days and entered a Medicare-approved<br>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                                                         |
| <b>Blood</b>                                                                                                                                                                                                                                   |                                                                                                         |                                                                   |                                                                   |
| First 3 pints                                                                                                                                                                                                                                  | \$0                                                                                                     | 3 pints                                                           | \$0                                                               |
| Additional amounts                                                                                                                                                                                                                             | 100%                                                                                                    | \$0                                                               | \$0                                                               |
| <b>Hospice Care</b><br>You must meet Medicare's requirements,<br>including a doctor's certification of<br>terminal illness                                                                                                                     | All but very limited<br>copayment/<br>coinsurance for<br>outpatient drugs and<br>inpatient respite care | Medicare copayment/<br>coinsurance                                | \$0                                                               |

# High Deductible Plan G

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

| Services                                                                                                                                                                                                                                                            | Medicare Pays | After You Pay<br>\$2,870 Deductible <sup>1</sup> ,<br>Plan G Pays | In Addition to \$2,870<br>Deductible <sup>1</sup> , 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 \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                               | \$0           | \$0                                                               | \$257 (Part B deductible)                                   |
| Remainder of Medicare-approved amounts                                                                                                                                                                                                                              | Generally 80% | Generally 20%                                                     | \$0                                                         |
| <b>Part B Excess Charges</b><br>(above Medicare-approved amounts)                                                                                                                                                                                                   | \$0           | 100%                                                              | \$0                                                         |
| <b>Blood</b>                                                                                                                                                                                                                                                        |               |                                                                   |                                                             |
| First 3 pints                                                                                                                                                                                                                                                       | \$0           | All costs                                                         | \$0                                                         |
| Next \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                                | \$0           | \$0                                                               | \$257 (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 | After You Pay<br>\$2,870 Deductible <sup>1</sup> ,<br>Plan G Pays | In Addition to \$2,870<br>Deductible <sup>1</sup> , You Pay |
|----------------------------------------------------------------|---------------|-------------------------------------------------------------------|-------------------------------------------------------------|
| Medically necessary skilled care services and medical supplies | 100%          | \$0                                                               | \$0                                                         |
| Durable medical equipment                                      |               |                                                                   |                                                             |
| – First \$257 of Medicare-approved amounts <sup>7</sup>        | \$0           | \$0                                                               | \$257 (Part B deductible)                                   |
| – Remainder of Medicare-approved amounts                       | 80%           | 20%                                                               | \$0                                                         |

## OTHER BENEFITS – NOT COVERED BY MEDICARE

|                                                                                                                                                                |     |                                               |                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----------------------------------------------|----------------------------------------------------|
| <b>Foreign Travel — Not Covered by Medicare</b><br>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          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------|------------------|
| <b>Hospitalization<sup>5</sup></b><br>Semiprivate room and board, general nursing, and miscellaneous services and supplies                                                                                                            |                                                                                            |                                    |                  |
| First 60 days                                                                                                                                                                                                                         | All but \$1,676                                                                            | \$1,676<br>(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 <sup>6</sup> |
| Beyond the additional 365 days                                                                                                                                                                                                        | \$0                                                                                        | \$0                                | All costs        |
| <b>Skilled Nursing Facility Care<sup>5</sup></b><br>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        |
| <b>Blood</b>                                                                                                                                                                                                                          |                                                                                            |                                    |                  |
| First 3 pints                                                                                                                                                                                                                         | \$0                                                                                        | 3 pints                            | \$0              |
| Additional amounts                                                                                                                                                                                                                    | 100%                                                                                       | \$0                                | \$0              |
| <b>Hospice Care</b><br>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                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------|---------------------------|
| <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 \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                               | \$0           | \$0              | \$257 (Part B deductible) |
| Remainder of Medicare-approved amounts                                                                                                                                                                                                                              | Generally 80% | Generally 20%    | \$0                       |
| <b>Part B Excess Charges</b><br>(above Medicare-approved amounts)                                                                                                                                                                                                   | \$0           | 100%             | \$0                       |
| <b>Blood</b>                                                                                                                                                                                                                                                        |               |                  |                           |
| First 3 pints                                                                                                                                                                                                                                                       | \$0           | All costs        | \$0                       |
| Next \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                                | \$0           | \$0              | \$257 (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 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 <sup>7</sup>        | \$0           | \$0              | \$257 (Part B deductible) |
| – Remainder of Medicare-approved amounts                       | 80%           | 20%              | \$0                       |

## OTHER BENEFITS – NOT COVERED BY MEDICARE

|                                                                                                                                                                |     |                                               |                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----------------------------------------------|----------------------------------------------------|
| <b>Foreign Travel — Not Covered by Medicare</b><br>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 |
|-----------------------------------------------|---------------|------------------|---------|
| <b>Diagnostic Evaluations</b>                 |               |                  |         |
| In Network                                    | \$0           | 100%             | \$0     |
| Out of Network                                | \$0           | 50%              | 50%     |
| <b>Preventive Services</b>                    |               |                  |         |
| In Network                                    | \$0           | 100%             | \$0     |
| Out of Network                                | \$0           | 50%              | 50%     |
| <b>Diagnostic Radiographs</b>                 |               |                  |         |
| In Network                                    | \$0           | 100%             | \$0     |
| Out of Network                                | \$0           | 50%              | 50%     |
| <b>Basic Restorative Services<sup>8</sup></b> | \$0           | 50%              | 50%     |
| <b>Non-Surgical Extractions</b>               |               |                  |         |
| In Network                                    | \$0           | 75%              | 25%     |
| Out of Network                                | \$0           | 50%              | 50%     |

### VISION

| Services                          | Medicare Pays | Plan G Plus Pays | You Pay           |
|-----------------------------------|---------------|------------------|-------------------|
| <b>Annual Routine Examination</b> |               |                  |                   |
| In Network                        | \$0           | 100%             | \$0               |
| Out of Network                    | \$0           | All except \$40  | \$40              |
| <b>Materials Allowance</b>        |               |                  |                   |
| In Network                        | \$0           | \$130            | Remaining Balance |
| Out of Network                    | \$0           | \$65             | Remaining Balance |

### HEARING<sup>9</sup>

| Services                          | Medicare Pays | Plan G Plus Pays | You Pay           |
|-----------------------------------|---------------|------------------|-------------------|
| <b>Annual Routine Examination</b> | \$0           | 100%             | \$0               |
| <b>Hardware Discounts</b>         | \$0           | Generally 30%    | Remaining Balance |

# High Deductible Plan G Plus

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

| Services                                                                                                                                                                                                                              | Medicare Pays                                                                              | After You Pay<br>\$2,870 Deductible <sup>1</sup> ,<br>Plan G Plus Pays | In Addition to \$2,870<br>Deductible <sup>1</sup> , You Pay |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------|-------------------------------------------------------------|
| <b>Hospitalization<sup>5</sup></b><br>Semiprivate room and board, general nursing, and miscellaneous services and supplies                                                                                                            |                                                                                            |                                                                        |                                                             |
| First 60 days                                                                                                                                                                                                                         | All but \$1,676                                                                            | \$1,676<br>(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 <sup>6</sup>                                            |
| Beyond the additional 365 days                                                                                                                                                                                                        | \$0                                                                                        | \$0                                                                    | All costs                                                   |
| <b>Skilled Nursing Facility Care<sup>5</sup></b><br>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                                                   |
| <b>Blood</b>                                                                                                                                                                                                                          |                                                                                            |                                                                        |                                                             |
| First 3 pints                                                                                                                                                                                                                         | \$0                                                                                        | 3 pints                                                                | \$0                                                         |
| Additional amounts                                                                                                                                                                                                                    | 100%                                                                                       | \$0                                                                    | \$0                                                         |
| <b>Hospice Care</b><br>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                                                         |

# High Deductible Plan G Plus

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

| Services                                                                                                                                                                                                                                                            | Medicare Pays | After You Pay \$2,870 Deductible <sup>1</sup> , Plan G Plus Pays | In Addition to \$2,870 Deductible <sup>1</sup> , 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 \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                               | \$0           | \$0                                                              | \$257 (Part B deductible)                                |
| Remainder of Medicare-approved amounts                                                                                                                                                                                                                              | Generally 80% | Generally 20%                                                    | \$0                                                      |
| <b>Part B Excess Charges</b><br>(above Medicare-approved amounts)                                                                                                                                                                                                   | \$0           | 100%                                                             | \$0                                                      |
| <b>Blood</b>                                                                                                                                                                                                                                                        |               |                                                                  |                                                          |
| First 3 pints                                                                                                                                                                                                                                                       | \$0           | All costs                                                        | \$0                                                      |
| Next \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                                | \$0           | \$0                                                              | \$257 (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 | After You Pay \$2,870 Deductible <sup>1</sup> , Plan G Plus Pays | In Addition to \$2,870 Deductible <sup>1</sup> , You Pay |
|----------------------------------------------------------------|---------------|------------------------------------------------------------------|----------------------------------------------------------|
| Medically necessary skilled care services and medical supplies | 100%          | \$0                                                              | \$0                                                      |
| Durable medical equipment                                      |               |                                                                  |                                                          |
| – First \$257 of Medicare-approved amounts <sup>7</sup>        | \$0           | \$0                                                              | \$257 (Part B deductible)                                |
| – Remainder of Medicare-approved amounts                       | 80%           | 20%                                                              | \$0                                                      |

## OTHER BENEFITS – NOT COVERED BY MEDICARE

|                                                                                                                                                                |     |                                               |                                                    |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----------------------------------------------|----------------------------------------------------|
| <b>Foreign Travel — Not Covered by Medicare</b><br>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 |

# High Deductible Plan G Plus

## INNOVATIVE BENEFITS

### DENTAL

| Services                                      | Medicare Pays | Plan G Plus Pays | You Pay |
|-----------------------------------------------|---------------|------------------|---------|
| <b>Diagnostic Evaluations</b>                 |               |                  |         |
| In Network                                    | \$0           | 100%             | \$0     |
| Out of Network                                | \$0           | 50%              | 50%     |
| <b>Preventive Services</b>                    |               |                  |         |
| In Network                                    | \$0           | 100%             | \$0     |
| Out of Network                                | \$0           | 50%              | 50%     |
| <b>Diagnostic Radiographs</b>                 |               |                  |         |
| In Network                                    | \$0           | 100%             | \$0     |
| Out of Network                                | \$0           | 50%              | 50%     |
| <b>Basic Restorative Services<sup>8</sup></b> | \$0           | 50%              | 50%     |
| <b>Non-Surgical Extractions</b>               |               |                  |         |
| In Network                                    | \$0           | 75%              | 25%     |
| Out of Network                                | \$0           | 50%              | 50%     |

### VISION

| Services                          | Medicare Pays | Plan G Plus Pays | You Pay           |
|-----------------------------------|---------------|------------------|-------------------|
| <b>Annual Routine Examination</b> |               |                  |                   |
| In Network                        | \$0           | 100%             | \$0               |
| Out of Network                    | \$0           | All except \$40  | \$40              |
| <b>Materials Allowance</b>        |               |                  |                   |
| In Network                        | \$0           | \$130            | Remaining Balance |
| Out of Network                    | \$0           | \$65             | Remaining Balance |

### HEARING<sup>9</sup>

| Services                          | Medicare Pays | Plan G Plus Pays | You Pay           |
|-----------------------------------|---------------|------------------|-------------------|
| <b>Annual Routine Examination</b> | \$0           | 100%             | \$0               |
| <b>Hardware Discounts</b>         | \$0           | Generally 30%    | Remaining Balance |

# Plan N

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

| Services                                                                                                                                                                                                                              | Medicare Pays                                                                              | Plan N Pays                        | You Pay          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------|------------------|
| <b>Hospitalization<sup>5</sup></b><br>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 <sup>6</sup> |
| Beyond the additional 365 days                                                                                                                                                                                                        | \$0                                                                                        | \$0                                | All costs        |
| <b>Skilled Nursing Facility Care<sup>5</sup></b><br>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        |
| <b>Blood</b>                                                                                                                                                                                                                          |                                                                                            |                                    |                  |
| First 3 pints                                                                                                                                                                                                                         | \$0                                                                                        | 3 pints                            | \$0              |
| Additional amounts                                                                                                                                                                                                                    | 100%                                                                                       | \$0                                | \$0              |
| <b>Hospice Care</b><br>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 \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                               | \$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. |
| <b>Part B Excess Charges</b><br>(above Medicare-approved amounts)                                                                                                                                                                                                   | \$0           | \$0                                                                                                                                                                                                                                        | All costs                                                                                                                                                                                                              |
| <b>Blood</b>                                                                                                                                                                                                                                                        |               |                                                                                                                                                                                                                                            |                                                                                                                                                                                                                        |
| First 3 pints                                                                                                                                                                                                                                                       | \$0           | All costs                                                                                                                                                                                                                                  | \$0                                                                                                                                                                                                                    |
| Next \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                                | \$0           | \$0                                                                                                                                                                                                                                        | \$257 (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 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 \$257 of Medicare-approved amounts <sup>7</sup>        | \$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                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------|----------------------------------------------------|
| <b>Foreign Travel —<br/>Not Covered by Medicare</b><br>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          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|------------------------------------|------------------|
| <b>Hospitalization<sup>5</sup></b><br>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 <sup>6</sup> |
| Beyond the additional 365 days                                                                                                                                                                                                        | \$0                                                                                        | \$0                                | All costs        |
| <b>Skilled Nursing Facility Care<sup>5</sup></b><br>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        |
| <b>Blood</b>                                                                                                                                                                                                                          |                                                                                            |                                    |                  |
| First 3 pints                                                                                                                                                                                                                         | \$0                                                                                        | 3 pints                            | \$0              |
| Additional amounts                                                                                                                                                                                                                    | 100%                                                                                       | \$0                                | \$0              |
| <b>Hospice Care</b><br>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                                                                                                                                                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <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 \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                               | \$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. |
| <b>Part B Excess Charges</b><br>(above Medicare-approved amounts)                                                                                                                                                                                                   | \$0           | \$0                                                                                                                                                                                                                                        | All costs                                                                                                                                                                                                              |
| <b>Blood</b>                                                                                                                                                                                                                                                        |               |                                                                                                                                                                                                                                            |                                                                                                                                                                                                                        |
| First 3 pints                                                                                                                                                                                                                                                       | \$0           | All costs                                                                                                                                                                                                                                  | \$0                                                                                                                                                                                                                    |
| Next \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                                | \$0           | \$0                                                                                                                                                                                                                                        | \$257 (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 Plus 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 \$257 of Medicare-approved amounts <sup>7</sup>                                                                                                                                                                                                             | \$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                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------|----------------------------------------------------|
| <b>Foreign Travel —<br/>Not Covered by Medicare</b><br>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 |
|-----------------------------------------------|---------------|------------------|---------|
| <b>Diagnostic Evaluations</b>                 |               |                  |         |
| In Network                                    | \$0           | 100%             | \$0     |
| Out of Network                                | \$0           | 50%              | 50%     |
| <b>Preventive Services</b>                    |               |                  |         |
| In Network                                    | \$0           | 100%             | \$0     |
| Out of Network                                | \$0           | 50%              | 50%     |
| <b>Diagnostic Radiographs</b>                 |               |                  |         |
| In Network                                    | \$0           | 100%             | \$0     |
| Out of Network                                | \$0           | 50%              | 50%     |
| <b>Basic Restorative Services<sup>8</sup></b> | \$0           | 50%              | 50%     |
| <b>Non-Surgical Extractions</b>               |               |                  |         |
| In Network                                    | \$0           | 75%              | 25%     |
| Out of Network                                | \$0           | 50%              | 50%     |

### VISION

| Services                          | Medicare Pays | Plan N Plus Pays | You Pay           |
|-----------------------------------|---------------|------------------|-------------------|
| <b>Annual Routine Examination</b> |               |                  |                   |
| In Network                        | \$0           | 100%             | \$0               |
| Out of Network                    | \$0           | All except \$40  | \$40              |
| <b>Materials Allowance</b>        |               |                  |                   |
| In Network                        | \$0           | \$130            | Remaining Balance |
| Out of Network                    | \$0           | \$65             | Remaining Balance |

### HEARING<sup>9</sup>

| Services                          | Medicare Pays | Plan N Plus Pays | You Pay           |
|-----------------------------------|---------------|------------------|-------------------|
| <b>Annual Routine Examination</b> | \$0           | 100%             | \$0               |
| <b>Hardware Discounts</b>         | \$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.

Medicare Supplement insurance plans are offered by 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.



## 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:  
a) age 65 or over or b) 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 7 and 8. 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.

- |                                                 |                                                 |                                                 |                                             |
|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> <b>Plan A</b>          | <input type="checkbox"/> <b>Plan F Plus</b>     | <input type="checkbox"/> <b>Plan G Plus</b>     | <input type="checkbox"/> <b>Plan N</b>      |
| <input type="checkbox"/> <b>Plan F</b>          | <input type="checkbox"/> <b>Plan G</b>          | <input type="checkbox"/> Standard               | <input type="checkbox"/> Standard           |
| <input type="checkbox"/> Standard               | <input type="checkbox"/> Standard               | <input type="checkbox"/> Medicare Select        | <input type="checkbox"/> Medicare Select    |
| <input type="checkbox"/> Medicare Select        | <input type="checkbox"/> Medicare Select        | <input type="checkbox"/> <b>High Deductible</b> | <input type="checkbox"/> <b>Plan N Plus</b> |
| <input type="checkbox"/> <b>High Deductible</b> | <input type="checkbox"/> <b>High Deductible</b> | <input type="checkbox"/> <b>Plan G Plus</b>     |                                             |
| <input type="checkbox"/> <b>Plan F</b>          | <input type="checkbox"/> <b>Plan G</b>          |                                                 |                                             |

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

Note: Plans F and High Deductible F are only available if you are Medicare-eligible prior to 2020.

### Applicant Information

|                                                                                                                          |                        |                 |               |                      |
|--------------------------------------------------------------------------------------------------------------------------|------------------------|-----------------|---------------|----------------------|
| Name (First)                                                                                                             |                        | (Middle)        | (Last)        |                      |
| Home Address (No P.O. Boxes)                                                                                             |                        | City            | State<br>IL   | ZIP                  |
| Correspondence / Billing Address                                                                                         |                        | City            | State         | ZIP                  |
| Primary Phone                                                                                                            |                        | Secondary Phone | Age           | Date of Birth<br>/ / |
| Gender<br><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 |
|------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|

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<sup>SM</sup> 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<sup>SM</sup>

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?                                                                                                                                                                                                                                           | <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?<br><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.<br><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 |

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

| Consumer Protection Information                                                                                                          |                              |                             |
|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 5. Do you have another Medicare Supplement policy in force?                                                                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| a. If <b>so</b> , with what company, and what plan do you have? _____                                                                    |                              |                             |
| b. If <b>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 |
| a. If <b>so</b> , with what company, and what kind of policy?<br>(For example, an employer, union, or individual plan) _____             |                              |                             |
| b. What are your dates of coverage under the other policy?<br>(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 9, or visit **[www.bcbsil.com](http://www.bcbsil.com)**.

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

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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|
| <b>Proxy Statement</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                 |
| The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), 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 HCSC (and at all meetings of members of any successor of HCSC) 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:

**Please return the completed application to your agent or:**

Blue Medicare Supplement<sup>SM</sup>  
c/o Member Services  
PO Box 3388  
Scranton, PA 18505

Medicare Supplement insurance plans are offered by 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.

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



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 \$1,676                                                                             |                        | <input type="checkbox"/> \$1,676 Part A Deductible* <b>or</b><br><input type="checkbox"/> \$0 Plan A Only                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> \$0 <b>or</b><br><input type="checkbox"/> \$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                                                                                                                                                                                                                                         |
| <b>Skilled Nursing Home Care</b>   | Days 1-20                                                                                                                                                           | All costs                                                                                   |                        | \$0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | \$0                                                                                                                                                                                                                                         |
|                                    | Days 21-100                                                                                                                                                         | All but \$209.50 a day                                                                      |                        | <input type="checkbox"/> \$209.50 a day <b>or</b><br><input type="checkbox"/> \$0 Plan A only                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> \$0 <b>or</b><br><input type="checkbox"/> \$209.50 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 \$257 deductible per calendar year |                        | <input type="checkbox"/> 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<br><input type="checkbox"/> 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.<br><input type="checkbox"/> \$257 Part B deductible for Plans F, High F and F Plus<br><input type="checkbox"/> 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<br><br><input type="checkbox"/> \$257 Part B deductible for Plans A, G, G Plus, High G, High G Plus, N, and N Plus.<br><input type="checkbox"/> 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.



## 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.