BlueCross BlueShield of Illinois

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

Outline of Medicare Supplement Coverage — Standard Benefits for Plans A, F, High Deductible F[1], F Plus, G, G Plus, High Deductible G[1], High Deductible G Plus[1] N, and N Plus.

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and High Deductible F.

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

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

Benefits	**Plans Available to All Applicants**								**Medicare first eligible before 2020 only**	
	A	**B**	**D**	**G[1]**	**K[2]**	**L[2]**	**M**	**N**	**C**	**F[1]**
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	copays apply[3]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit in 2024[2]					$7,060[2]	$3,530[2]				

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[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2,800 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.

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

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

Monthly Premium Rates effective April 1, 2024

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

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

Age 65				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$132.98	$120.90	$151.57	$137.78
F	$208.93	$189.93	$238.11	$216.46
High F[1]	$60.02	$54.56	$68.40	$62.19
F Plus	$232.50	$213.50	$261.68	$240.03
G	$161.89	$147.19	$187.30	$170.27
High G[1]	$57.15	$51.96	$65.15	$59.23
G Plus	$185.46	$170.76	$210.87	$193.84
High G Plus	$80.72	$75.53	$88.72	$82.80
N	$140.92	$128.11	$163.03	$148.21
N Plus	$164.49	$151.68	$186.60	$ 171.78

Age 66

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$141.22	$128.37	$160.95	$146.31
F	$221.84	$201.69	$252.84	$229.85
High F[1]	$63.73	$57.92	$72.63	$66.02
F Plus	$245.41	$225.26	$276.41	$253.42
G	$173.16	$157.42	$200.12	$181.94
High G[1]	$60.70	$55.17	$69.17	$62.89
G Plus	$196.73	$180.99	$223.69	$205.51
High G Plus	$84.27	$78.74	$92.74	$86.46
N	$150.70	$137.01	$174.18	$158.35
N Plus	$174.27	$160.58	$197.75	$181.92

Age 67

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$149.30	$135.72	$170.15	$154.68
F	$234.53	$213.22	$267.32	$243.00
High F[1]	$67.37	$61.26	$76.79	$69.79
F Plus	$258.10	$236.79	$290.89	$266.57
G	$184.19	$167.46	$212.71	$193.36
High G[1]	$64.16	$58.34	$73.13	$66.47
G Plus	$207.76	$191.03	$236.28	$216.93
High G Plus	$87.73	$81.91	$96.70	$90.04
N	$160.32	$145.76	$185.14	$168.31
N Plus	$183.89	$169.33	$208.71	$191.88

Age 68

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$157.23	$142.93	$179.19	$162.91
F	$247.00	$224.54	$281.51	$255.92
High F[1]	$70.96	$64.51	$80.87	$73.50
F Plus	$270.57	$248.11	$305.08	$279.49
G	$195.04	$177.31	$225.07	$204.61
High G[1]	$67.58	$61.43	$77.01	$70.01
G Plus	$218.61	$200.88	$248.64	$228.18
High G Plus	$91.15	$85.00	$100.58	$93.58
N	$169.77	$154.33	$195.90	$178.10
N Plus	$193.34	$177.90	$219.47	$201.67

Age 69

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$165.01	$150.02	$188.07	$170.96
F	$259.24	$235.67	$295.46	$268.59
High F[1]	$74.47	$67.69	$84.88	$77.17
F Plus	$282.81	$259.24	$319.03	$292.16
G	$205.70	$186.98	$237.20	$215.63
High G[1]	$70.92	$64.48	$80.84	$73.48
G Plus	$229.27	$210.55	$260.77	$239.20
High G Plus	$94.49	$88.05	$104.41	$97.05
N	$179.03	$162.76	$206.47	$187.68
N Plus	$202.60	$186.33	$230.04	$211.25

Age 70				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$172.65	$156.96	$196.77	$178.89
F	$271.23	$246.57	$309.14	$281.04
High F[1]	$77.92	$70.83	$88.80	$80.73
F Plus	$294.80	$270.14	$332.71	$304.61
G	$216.12	$196.48	$249.11	$226.47
High G[1]	$74.21	$67.46	$84.57	$76.89
G Plus	$239.69	$220.05	$272.68	$250.04
High G Plus	$97.78	$91.03	108.14	$100.46
N	$188.13	$171.02	$216.83	$197.12
N Plus	$211.70	$194.59	$240.40	$220.69

Age 71				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$180.13	$163.76	$205.31	$186.65
F	$283.00	$257.28	$322.55	$293.21
High F[1]	$81.29	$73.92	$92.65	$84.22
F Plus	$306.57	$280.85	$346.12	$316.78
G	$226.38	$205.78	$260.79	$237.07
High G[1]	$77.43	$70.39	$88.24	$80.21
G Plus	$249.95	$229.35	$284.36	$260.64
High G Plus	$101.00	$93.96	$111.81	$103.78
N	$197.04	$179.13	$226.99	$206.34
N Plus	$220.61	$202.70	$250.56	$229.91

Age 72				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$187.49	$170.45	$213.67	$194.26
F	$294.55	$267.76	$335.70	$305.19
High F[1]	$84.62	$76.93	$96.43	$87.66
F Plus	$318.12	$291.33	$359.27	$328.76
G	$236.42	$214.92	$272.22	$247.47
High G[1]	$80.59	$73.26	$91.84	$83.49
G Plus	$259.99	$238.49	$295.79	$271.04
High G Plus	$104.16	$96.83	$115.41	$107.06
N	$ 205.78	$187.08	$236.95	$215.42
N Plus	$229.35	$210.65	$260.52	$238.99

Age 73				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$194.70	$176.99	$221.89	$201.72
F	$305.85	$278.06	$348.59	$316.89
High F[1]	$87.86	$79.88	$100.15	$91.03
F Plus	$329.42	$301.63	$372.16	$340.46
G	$246.25	$233.86	$283.44	$257.67
High G[1]	$83.67	$76.08	$95.37	$86.70
G Plus	$269.82	$247.43	$307.01	$281.24
High G Plus	$107.24	$99.65	$118.94	$110.27
N	$214.35	$194.86	$246.72	$224.28
N Plus	$237.92	$218.43	$270.29	$247.85

Age 74				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$201.74	$183.39	$229.92	$209.01
F	$316.93	$288.11	$361.21	$328.37
High F[1]	$91.04	$82.77	$103.76	$94.33
F Plus	$340.50	$311.68	$384.78	$351.94
G	$255.90	$232.64	$294.42	$267.67
High G[1]	$86.71	$78.83	$98.82	$89.83
G Plus	$279.47	$256.21	$317.99	$291.24
High G Plus	$110.28	$102.40	$122.39	$113.40
N	$222.74	$202.49	$256.26	$232.99
N Plus	$246.31	$226.06	$279.83	$256.56

Age 75				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$208.65	$189.68	$237.78	$216.17
F	$327.77	$297.98	$373.56	$339.61
High F[1]	$94.14	$85.59	$107.30	$97.56
F Plus	$351.34	$321.55	$397.13	$363.18
G	$265.33	$241.21	$305.19	$277.44
High G[1]	$89.67	$81.52	$102.19	$92.91
G Plus	$288.90	$264.78	$328.76	$301.01
High G Plus	$113.24	$105.09	$125.76	$116.48
N	$230.95	$209.95	$265.64	$241.49
N Plus	$254.52	$233.52	$289.21	$265.06

Age 76				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$215.40	$195.83	$245.48	$223.17
F	$338.39	$307.64	$385.67	$350.61
High F[1]	$97.21	$88.38	$110.78	$100.72
F Plus	$361.96	$331.21	$409.24	$374.18
G	$274.57	$249.61	$315.72	$287.02
High G[1]	$92.59	$84.16	$105.51	$95.93
G Plus	$298.14	$273.18	$339.29	$310.59
High G Plus	$116.16	$107.73	$129.08	$119.50
N	$238.99	$217.26	$274.81	$249.81
N Plus	$262.56	$240.83	$298.38	$273.38

Age 77				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$222.02	$201.82	$253.02	$230.02
F	$348.79	$317.08	$397.50	$361.38
High F[1]	$100.19	$91.08	$114.18	$103.8
F Plus	$372.36	$340.65	$421.07	$384.95
G	$283.61	$257.83	$326.02	$296.38
High G[1]	$95.42	$86.75	$108.75	$98.86
G Plus	$307.18	$281.40	$349.59	$319.95
High G Plus	$118.99	$110.32	$132.32	$122.43
N	$246.86	$224.42	$283.77	$257.98
N Plus	$270.43	$247.99	$307.34	$281.55

Age 78

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$228.48	$207.71	$260.39	$236.71
F	$358.94	$326.31	$409.08	$371.89
High F[1]	$103.11	$93.74	$117.51	$106.83
F Plus	$382.51	$349.88	$432.65	$395.46
G	$292.45	$265.85	$336.09	$305.53
High G[1]	$98.19	$89.27	$111.92	$101.75
G Plus	$316.02	$289.42	$359.66	$329.10
High G Plus	$121.76	$112.84	$135.49	$125.32
N	$254.55	$231.41	$292.54	$265.94
N Plus	$278.12	$254.98	$316.11	$289.51

Age 79

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$234.79	$213.44	$267.58	$243.26
F	$368.86	$335.32	$420.39	$382.17
High F[1]	$105.95	$96.34	$120.77	$109.78
F Plus	$392.43	$358.89	$443.96	$405.74
G	$301.08	$273.70	$345.92	$314.49
High G[1]	$100.92	$91.74	$115.01	$104.54
G Plus	$324.65	$297.27	$369.49	$338.06
High G Plus	$124.49	115.31	$138.58	$128.11
N	$262.06	$238.24	$301.10	$273.73
N Plus	$285.63	$261.81	$324.67	$297.30

Age 80				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$240.96	$219.06	$274.62	$249.65
F	$378.55	$344.12	$431.44	$392.21
High F[1]	$108.73	$98.85	$123.93	$112.68
F Plus	$112.68	$367.69	$455.01	$415.78
G	$309.53	$281.38	$355.55	$323.22
High G[1]	$103.55	$94.14	$118.02	$107.30
G Plus	$333.10	$304.95	$379.12	$346.79
High G Plus	$127.12	$117.71	$141.59	$130.87
N	$269.41	$244.91	$309.47	$281.33
N Plus	$292.98	$268.48	$333.04	$304.90

Age 81				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	246.97	$224.53	$281.48	$255.90
F	$388.00	$352.72	$442.22	$402.01
High F[1]	$111.46	$101.33	$127.03	$115.48
F Plus	$411.57	$376.29	$465.79	$425.58
G	$317.75	$288.86	$364.93	$331.74
High G[1]	$106.14	$96.50	$120.98	$109.98
G Plus	$341.32	$312.43	$388.50	$355.31
High G Plus	$129.71	$120.07	$144.55	$133.55
N	$276.57	$251.42	$317.63	$288.76
N Plus	$300.14	$274.99	$341.20	$312.33

Age 82

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$252.86	$229.87	$288.17	$261.99
F	$397.23	$361.13	$452.74	$411.58
High F[1]	$114.11	$103.73	$130.04	$118.22
F Plus	$420.80	$384.70	$476.31	$435.15
G	$325.78	$296.16	$374.08	$340.06
High G[1]	$108.68	$98.80	$123.85	$112.59
G Plus	$349.35	$319.73	$397.65	$363.63
High G Plus	$132.25	$122.37	$147.42	$136.16
N	$283.56	$257.79	$325.60	$296.01
N Plus	$307.13	$281.36	$349.17	$319.58

Age 83

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$258.58	$235.07	$294.71	$267.93
F	$406.24	$369.32	$462.99	$420.90
High F[1]	$116.70	$106.09	$133.00	$120.91
F Plus	$429.81	$392.89	$486.56	$444.47
G	$333.61	$303.29	$383.01	$348.19
High G[1]	$111.14	$101.03	$126.67	$115.15
G Plus	$357.18	$326.86	$406.58	$371.76
High G Plus	$134.71	$124.60	$150.24	$138.72
N	$290.39	$263.98	$333.37	$303.06
N Plus	$313.96	$287.55	$356.94	$326.63

Age 84

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$264.17	$240.15	$301.07	$273.69
F	$415.00	$377.27	$472.98	$429.99
High F[1]	$119.21	$108.39	$135.87	$123.52
F Plus	$438.57	$400.84	$496.55	$453.56
G	$ 341.24	$310.23	$391.71	$356.09
High G[1]	$113.54	$103.22	$129.41	$117.63
G Plus	$364.81	$333.80	$415.28	$379.66
High G Plus	$137.11	$126.79	$152.98	$141.20
N	$297.03	$270.03	$340.95	$309.95
N Plus	$320.60	$293.60	$364.52	$333.52

Age 85

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$269.59	$245.10	$307.26	$279.34
F	$423.54	$385.05	$482.71	$438.84
High F[1]	$121.66	$110.61	$138.67	$126.05
F Plus	$447.11	$408.62	$506.28	$462.41
G	$348.69	$316.98	$400.17	$363.79
High G[1]	$115.86	$105.34	$132.06	$120.05
G Plus	$372.26	$340.55	$423.74	$387.36
High G Plus	$139.43	$128.91	$155.63	$143.62
N	$303.49	$275.90	$348.31	$316.66
N Plus	$327.06	$299.47	$371.88	$340.23

Age 86

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$274.89	$249.89	$313.30	$284.81
F	$431.85	$392.58	$492.19	$447.43
High F[1]	$124.06	$112.78	$141.38	$128.53
F Plus	$455.42	$416.15	$515.76	$471.00
G	$355.90	$323.55	$408.40	$371.27
High G[1]	$118.15	$107.42	$134.65	$122.41
G Plus	$379.47	$347.12	$431.97	$394.84
High G Plus	$141.72	$130.99	$158.22	$145.98
N	$309.79	$281.62	$355.48	$323.16
N Plus	$333.36	$305.19	$379.05	$346.73

Age 87

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$280.03	$254.57	$319.14	$290.14
F	$439.94	$399.95	$501.39	$455.80
High F[1]	$126.38	$114.89	$144.01	$130.94
F Plus	$463.51	$423.52	$524.96	$479.37
G	$362.93	329.94	$416.42	$378.56
High G[1]	$120.36	109.41	$137.16	$124.70
G Plus	$386.50	$353.51	$439.99	$402.13
High G Plus	$143.93	$132.98	$160.73	$148.27
N	$315.90	$287.18	$362.46	$329.51
N Plus	$339.47	$310.75	$386.03	$353.08

Age 88

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$285.02	$259.10	$324.84	$295.32
F	$447.77	$407.06	$510.32	$463.92
High F[1]	$128.62	$116.93	$146.59	$133.26
F Plus	$471.34	$430.63	$533.89	$487.49
G	$369.76	$336.15	$424.19	$385.64
High G[1]	$122.49	$111.37	$139.61	$126.92
G Plus	$393.33	$359.72	$447.76	$409.21
High G Plus	$146.06	$134.94	$163.18	$150.49
N	$321.84	$292.58	$369.22	$335.66
N Plus	$345.41	$316.15	$392.79	$359.23

Age 89

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$289.87	$263.51	$330.36	$300.33
F	$455.39	$413.99	$519.00	$471.82
High F[1]	$130.81	$118.92	$149.08	$135.54
F Plus	$478.96	$437.56	$542.57	$495.39
G	$376.39	$342.18	$431.75	$392.49
High G[1]	$124.58	$113.26	$141.99	$129.08
G Plus	$399.96	$365.75	$455.32	$416.06
High G Plus	$148.15	$136.83	$165.56	$152.65
N	$327.61	$297.83	$375.81	$341.64
N Plus	$351.18	$321.40	$399.38	$365.21

Age 90				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$294.56	$267.78	$335.73	$305.20
F	$462.77	$420.69	$527.42	$479.47
High F[1]	$132.94	$120.84	$151.50	$137.73
F Plus	$486.34	$444.26	$550.99	$503.04
G	$382.82	$348.01	$439.08	$399.17
High G[1]	$126.61	$115.10	$144.30	$131.18
G Plus	$406.39	$371.58	$462.65	$422.74
High G Plus	$150.18	$138.67	$167.87	$154.75
N	$333.21	$302.92	$382.17	$347.44
N Plus	$356.78	$326.49	$405.74	$371.01

Age 91				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$299.12	$271.93	$340.91	$309.92
F	$469.93	$427.19	$535.56	$486.87
High F[1]	$134.99	$122.72	$153.85	$139.87
F Plus	$493.50	$450.76	$559.13	$510.44
G	$389.03	$353.67	$446.17	$405.60
High G[1]	$128.56	$116.88	$146.52	$133.21
G Plus	$412.6	$377.24	$469.74	$429.17
High G Plus	$152.13	$140.45	$170.09	$156.78
N	$338.62	$307.84	$388.34	$353.05
N Plus	$362.19	$331.41	$411.91	$376.62

Age 92				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$303.52	$275.94	$345.92	$314.49
F	$476.84	$433.49	$543.46	$494.06
High F[1]	$136.98	$124.53	$156.12	$141.93
F Plus	$500.41	$457.06	$567.03	$517.63
G	$395.06	$359.14	$453.03	$411.85
High G[1]	$130.45	$118.61	$148.68	$135.16
G Plus	$418.63	$382.71	$476.60	$435.42
High G Plus	$154.02	$142.18	$172.25	$158.73
N	$343.86	$312.61	$394.33	$358.47
N Plus	$367.43	$336.18	$417.90	$382.04

Age 93				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$307.78	$279.81	$350.78	$318.88
F	$483.53	$439.57	$551.09	$500.98
High F[1]	$138.90	$126.26	$158.31	$143.91
F Plus	$507.10	$463.14	$574.66	$524.55
G	$400.89	$364.45	$459.67	$417.87
High G[1]	$132.29	$120.26	$150.77	$137.06
G Plus	$424.46	$388.02	$483.24	$441.44
High G Plus	$155.86	$143.83	$174.34	$160.63
N	$348.94	$317.21	$400.10	$363.72
N Plus	$372.51	$340.78	$423.67	$387.29

Age 94				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$311.89	$283.54	$355.47	$323.15
F	$490.00	$445.44	$558.44	$507.68
High F[1]	$140.76	$127.96	$160.43	$145.83
F Plus	$513.57	$469.01	$582.01	$531.25
G	$ 406.50	$369.55	$466.07	$423.71
High G[1]	$134.05	$121.87	$152.79	$138.89
G Plus	$430.07	$393.12	$489.64	$447.28
High G Plus	$157.62	$145.44	$176.36	$162.46
N	$353.83	$321.66	$405.68	$368.80
N Plus	$377.4	$345.23	$429.25	$392.37

Age 95				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$315.87	$287.15	$359.97	$327.26
F	$496.23	$451.12	$565.54	$514.12
High F[1]	$142.54	$129.58	$162.45	$147.69
F Plus	$519.80	$474.69	$589.11	$537.69
G	$411.92	$374.47	$472.25	$429.32
High G[1]	$135.76	$123.41	$154.72	$140.66
G Plus	$435.49	$398.04	$495.82	$452.89
High G Plus	$159.33	$146.98	$178.29	$164.23
N	$358.54	$325.94	$411.05	$373.68
N Plus	$382.11	$349.51	$434.62	$397.25

Age 96				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$319.68	$290.62	$364.34	$331.23
F	$502.21	$456.56	$572.37	$520.33
High F[1]	$144.26	$131.17	$164.43	$149.46
F Plus	$525.78	$480.13	$595.94	$543.90
G	$417.14	$379.22	$478.19	$434.73
High G[1]	$137.40	$124.91	$156.59	$142.34
G Plus	$440.71	$402.79	$501.76	$458.3
High G Plus	$160.97	$148.48	$180.16	$165.91
N	$363.07	$330.08	$416.22	$378.39
N Plus	$386.64	$353.65	$439.79	$401.96

Age 97				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$323.34	$293.95	$368.51	$335.02
F	$507.99	$461.81	$578.94	$526.32
High F[1]	$145.92	$132.66	$166.31	$151.19
F Plus	$531.56	$485.38	$602.51	$549.89
G	$422.17	$383.78	$483.92	$439.92
High G[1]	$138.97	$126.35	$158.38	$143.99
G Plus	$445.74	$407.35	$507.49	$463.49
High G Plus	$162.54	$149.92	$181.95	$167.56
N	$367.45	$334.05	$421.20	$382.91
N Plus	$391.02	$357.62	$444.77	$406.48

Age 98

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$326.86	$297.15	$372.52	$338.67
F	$513.53	$466.83	$585.25	$532.05
High F[1]	$147.50	$134.09	$168.11	$152.84
F Plus	$537.1	$490.40	$ 608.82	$555.62
G	$426.97	$388.16	$489.41	$444.92
High G[1]	$140.48	$127.72	$160.12	$145.56
G Plus	$450.54	$411.73	$512.98	$468.49
High G Plus	$164.05	$151.29	$183.69	$169.13
N	$371.65	$337.87	$426.00	$387.26
N Plus	$395.22	$361.44	$449.57	$410.83

Age 99

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$330.25	$300.22	$376.39	$342.17
F	$518.82	$471.65	$591.30	$537.54
High F[1]	$149.04	$135.49	$169.86	$154.41
F Plus	$542.39	$495.22	$614.87	$561.11
G	$431.59	$392.35	$494.67	$449.70
High G[1]	$141.94	$129.04	$161.77	$147.06
G Plus	$455.16	$415.92	$ 518.24	$ 473.27
High G Plus	$165.51	$152.61	$185.34	$170.63
N	$375.67	$341.52	$430.56	$391.42
N Plus	$399.24	$365.09	$454.13	$414.99

Age 100 +				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$333.48	$303.17	$380.06	$345.50
F	$523.91	$476.28	$597.08	$542.81
High F[1]	$150.51	$136.81	$171.51	$155.92
F Plus	$547.48	$499.85	$620.65	$566.38
G	$436.01	$396.37	$499.69	$454.28
High G[1]	$143.34	$130.29	$163.35	$148.49
G Plus	$459.58	$419.94	$523.26	$477.85
High G Plus	$166.91	$153.86	$186.92	$172.06
N	$379.50	$345.02	$434.94	$395.41
N Plus	$403.07	$368.59	$458.51	$418.98

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

PREMIUM INFORMATION

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

Gender

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

Tobacco User

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

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

PREMIUM DISCOUNTS

A Blue Cross and Blue Shield of Illinois Medicare Supplement premium discount may be available. Eligibility criteria are described below. If you are eligible for a discount, the discount will be applied to your next bill and remain in effect as long as you are enrolled in your BCBSIL Medicare Supplement plan. Discounts cannot be combined; only one type of discount per member is permitted.

Household Discount

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

Continue with Blue℠ Discount

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

Blue Family Discount℠

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

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN YOUR POLICY

If you find that you are not satisfied with your policy, you may return it to **Blue Medicare Supplement℠ c/o Member Services, P.O. Box 3388 Scranton, PA 18505**. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and will return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither Blue Cross and Blue Shield of Illinois nor its agents are connected with Medicare. This Outline of Coverage does not give you all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare & You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

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

Plan A

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

Services	Medicare Pays	Plan A Pays	You Pay
Hospitalization[4] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$0	$1,632 (Part A deductible)
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[5]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[4] 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 $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

[4] 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.

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

Plan A

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

Services	Medicare Pays	Plan A Pays	You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan A Pays	You Pay
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0

[6] Once you have been billed $240 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan F

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD			
Services	**Medicare Pays**	**Plan F Pays**	**You Pay**
Hospitalization[4] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[5]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[4] 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

Plan F

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan F Pays**	**You Pay**
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts[6]	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts[6]	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0
MEDICARE (PARTS A & B)			
Services	**Medicare Pays**	**Plan F Pays**	**You Pay**
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $240 of Medicare-approved amounts[6]	$0	$240 (Part B deductible)	$0
– Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

High Deductible Plan F

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

Services	Medicare Pays	After You Pay $2,800 Deductible[1], Plan F Pays	In Addition to $2,800 Deductible[1], You Pay
Hospitalization[4] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[5]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[4] 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

High Deductible Plan F

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**After You Pay $2,800 Deductible[1], Plan F Pays**	**In Addition to $2,800 Deductible[1], You Pay**
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts[6]	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts[6]	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0
MEDICARE (PARTS A & B)			
Services	**Medicare Pays**	**After You Pay $2,800 Deductible[1], Plan F Pays**	**In Addition to $2,800 Deductible[1], You Pay**
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $240 of Medicare-approved amounts[6]	$0	$240 (Part B deductible)	$0
– Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan F Plus

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD			
Services	**Medicare Pays**	**Plan F Plus Pays**	**You Pay**
Hospitalization[4] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[5]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[4] 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

Plan F Plus

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan F Plus Pays**	**You Pay**
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts[6]	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts[6]	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0
MEDICARE (PARTS A & B)			
Services	**Medicare Pays**	**Plan F Plus Pays**	**You Pay**
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $240 of Medicare-approved amounts[6]	$0	$240 (Part B deductible)	$0
– Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan F Plus

INNOVATIVE BENEFITS			
DENTAL			
Services	**Medicare Pays**	**Plan F Plus Pays**	**You Pay**
Diagnostic Evaluations			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Preventive Services			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Diagnostic Radiographs			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Basic Restorative Services[7]	$0	50%	50%
Non-Surgical Extractions			
In Network	$0	75%	25%
Out of Network	$0	50%	50%
VISION			
Services	**Medicare Pays**	**Plan F Plus Pays**	**You Pay**
Annual Routine Examination			
In Network	$0	100%	$0
Out of Network	$0	All except $40	$40
Materials Allowance			
In Network	$0	$130	Remaining Balance
Out of Network	$0	$65	Remaining Balance
HEARING[8]			
Services	**Medicare Pays**	**Plan F Plus Pays**	**You Pay**
Annual Routine Examination	$0	100%	$0
Hardware Discounts	$0	Generally 30%	Remaining Balance

[7] Once per tooth per calendar year.

[8] All services must be received in network.

Plan G

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

Services	Medicare Pays	Plan G Pays	You Pay
Hospitalization[4] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[5]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[4] 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

Plan G

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan G Pays**	**You Pay**
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0
MEDICARE (PARTS A & B)			
Services	**Medicare Pays**	**Plan G Pays**	**You Pay**
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

High Deductible Plan G

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

Services	Medicare Pays	After You Pay $2,800 Deductible[1], Plan G Pays	In Addition to $2,800 Deductible[1], You Pay
Hospitalization[4] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[5]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[4] 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

High Deductible Plan G

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

Services	Medicare Pays	After You Pay $2,800 Deductible[1], Plan G Pays	In Addition to $2,800 Deductible[1], You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	After You Pay $2,800 Deductible[1], Plan G Pays	In Addition to $2,800 Deductible[1], You Pay
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

Plan G Plus

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Hospitalization[4] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[5]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[4] 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

Plan G Plus

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0
MEDICARE (PARTS A & B)			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS – NOT COVERED BY MEDICARE			
Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan G Plus

INNOVATIVE BENEFITS			
DENTAL			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Diagnostic Evaluations			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Preventive Services			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Diagnostic Radiographs			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Basic Restorative Services[7]	$0	50%	50%
Non-Surgical Extractions			
In Network	$0	75%	25%
Out of Network	$0	50%	50%
VISION			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Annual Routine Examination			
In Network	$0	100%	$0
Out of Network	$0	All except $40	$40
Materials Allowance			
In Network	$0	$130	Remaining Balance
Out of Network	$0	$65	Remaining Balance
HEARING[8]			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Annual Routine Examination	$0	100%	$0
Hardware Discounts	$0	Generally 30%	Remaining Balance

High Deductible Plan G Plus

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

Services	Medicare Pays	After You Pay $2,800 Deductible[1], Plan G Plus Pays	In Addition to $2,800 Deductible[1], You Pay
Hospitalization[4] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[5]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[4] 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

High Deductible Plan G Plus

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**After You Pay $2,800 Deductible[1], Plan G Plus Pays**	**In Addition to $2,800 Deductible[1], You Pay**
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A & B)			
Services	**Medicare Pays**	**After You Pay $2,800 Deductible[1], Plan G Plus Pays**	**In Addition to $2,800 Deductible[1], You Pay**
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE			
Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

High Deductible Plan G Plus

INNOVATIVE BENEFITS

DENTAL

Services	Medicare Pays	Plan G Plus Pays	You Pay
Diagnostic Evaluations			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Preventive Services			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Diagnostic Radiographs			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Basic Restorative Services[7]	$0	50%	50%
Non-Surgical Extractions			
In Network	$0	75%	25%
Out of Network	$0	50%	50%

VISION

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

HEARING[8]

Services	Medicare Pays	Plan G Plus Pays	You Pay
Annual Routine Examination	$0	100%	$0
Hardware Discounts	$0	Generally 30%	Remaining Balance

Plan N

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD			
Services	**Medicare Pays**	**Plan N Pays**	**You Pay**
Hospitalization[4] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[5]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[4] 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

Plan N

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

Services	Medicare Pays	Plan N Pays	You Pay
Medical Expenses — In or Out of the Hospital And Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan N Pays	You Pay
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0

Plan N

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

Plan N Plus

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

Services	Medicare Pays	Plan N Plus Pays	You Pay
Hospitalization[4] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $816 a day	$816 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[5]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[4] 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

Plan N Plus

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

Services	Medicare Pays	Plan N Plus Pays	You Pay
Medical Expenses — In or Out of the Hospital And Outpatient Hospital Treatment, such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan N Plus Pays	You Pay
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $240 of Medicare-approved amounts[6]	$0	$0	$240 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0

Plan N Plus

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

Plan N Plus

INNOVATIVE BENEFITS			
DENTAL			
Services	**Medicare Pays**	**Plan N Plus Pays**	**You Pay**
Diagnostic Evaluations			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Preventive Services			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Diagnostic Radiographs			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Basic Restorative Services[7]	$0	50%	50%
Non-Surgical Extractions			
In Network	$0	75%	25%
Out of Network	$0	50%	50%
VISION			
Services	**Medicare Pays**	**Plan N Plus Pays**	**You Pay**
Annual Routine Examination			
In Network	$0	100%	$0
Out of Network	$0	All except $40	$40
Materials Allowance			
In Network	$0	$130	Remaining Balance
Out of Network	$0	$65	Remaining Balance
HEARING[8]			
Services	**Medicare Pays**	**Plan N Plus Pays**	**You Pay**
Annual Routine Examination	$0	100%	$0
Hardware Discounts	$0	Generally 30%	Remaining Balance

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

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.

BlueCross BlueShield of Illinois

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

Home Office Use Only

Application for Medicare Supplement Insurance Plan

Instructions

1. To be considered for coverage, you must have Medicare Parts A and B, reside in Illinois, and be: a) age 65 or over or b) applying within 6 months of your Medicare Part B effective date.
2. **If submitting a paper application, please complete in ink. Be sure to sign and date on the appropriate line(s) on pages 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.

- ☐ **Plan A**
- ☐ **Plan F**
  - ☐ Standard
  - ☐ Medicare Select
- ☐ **High Deductible Plan F**
- ☐ **Plan F Plus**
- ☐ **Plan G**
  - ☐ Standard
  - ☐ Medicare Select
- ☐ **High Deductible Plan G**
- **Plan G Plus**
  - ☐ Standard
  - ☐ Medicare Select
- ☐ **High Deductible Plan G Plus**
- **Plan N**
  - ☐ Standard
  - ☐ Medicare Select
- ☐ **Plan N Plus**

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 **IL**	ZIP
Correspondence / Billing Address	City	State	ZIP
Primary Phone	Secondary Phone	Age	Date of Birth ____/____/____
Gender ☐ Male ☐ Female	Social Security Number	Email Address	
Preferred Method of Contact: ☐ Mail ☐ Phone ☐ Email			

Tobacco Use

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

Within the past 6 months, have you used tobacco 4 or more times per week on average, excluding religious or ceremonial uses?	☐ Yes	☐ No

Applicant Name: _____

Premium Discounts

A BCBSIL Medicare Supplement premium discount may be available. Eligibility criteria are described below. If you are eligible for a discount, the discount will be applied to your next bill and remain in effect as long as you are enrolled in your BCBSIL Medicare Supplement plan. Discounts cannot be combined; only one type of discount per member is permitted.

Household Discount

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

Are you applying for this discount?	☐ Yes	☐ No

Continue with Blue℠ Discount

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

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

Blue Family Discount℠

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

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

Applicant Name: _____

Payment Option (Select one payment option)

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

Account holder name:	
Bank name:	
Bank routing number:	Bank account number:
Account Owner Signature (if different than applicant)	

Bank Draft Authorization Agreement

By signing this application, I request and authorize BCBSIL and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the financial institution named below to accept and honor the same to my account.

I understand that this request for coverage is not an employer group health plan and is not intended, in any way, to be an employer sponsored health insurance plan. I certify the employer(s) of those applying for coverage will not contribute any part of the premium or provide reimbursement for any part of the premium now or in the future.

I also understand that both the financial institution and BCBSIL reserve the right to terminate this payment program and/or my participation therein. To make changes to my financial institution I understand that I will need to provide at least 10 days advanced notice to BCBSIL by telephone prior to a scheduled withdrawal date. I authorize BCBSIL to deduct the premium payments from my checking or savings account. If the draft date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day.

2. ☐ Premium **to be billed by mail**

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

Medicare Beneficiary Identifier

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

Medicare Beneficiary Identifier ☐☐☐☐☐☐☐☐☐☐☐

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

Applicant Name: _____

Consumer Protection Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement Insurance Plans.
Please include a copy of the notice from your prior insurer with your application.

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

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

Applicant Name: _____

Consumer Protection Information		
5. Do you have another Medicare Supplement policy in force?	☐ Yes	☐ No
a. If <u>so</u>, with what company, and what plan do you have? _____		
b. If <u>so</u>, do you intend to replace your current Medicare Supplement policy with this policy?	☐ Yes	☐ No
6. Have you had coverage under any other health insurance within the past 63 days?	☐ Yes	☐ No
a. If <u>so</u>, with what company, and what kind of policy? *(For example, an employer, union, or individual plan)* _____		
b. What are your dates of coverage under the other policy? *(If you are still covered under the other policy, leave "End Date" blank.)*	Start Date:	End Date:

Applicant Name: _____

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

Questions?

Call us at our Customer Service toll-free number **877-384-9297**,
call your insurance agent at the number listed on page 9, or visit **www.bcbsil.com**.

Applicant Name: _____

Proxy Statement	
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℠
c/o Member Services
PO Box 3388
Scranton, PA 18505

BlueCross BlueShield of Illinois

Medicare Supplement Policy Checklist

Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____ Expiration Date of Existing Insurance ___/___/___

Service	Benefit	Medicare Pays	Existing Coverage Pays	Supplement Covers	You Pay
Hospital Inpatient Services	Days 1-60	All but $1,632		☐ $1,632 Part A Deductible* **or** ☐ $0 Plan A Only	☐ $0 **or** ☐ $1,632 Part A Deductible
	Days 61-90	All but $408 a day		$408 a day	$0
	Days 91-150 (Lifetime Reserve)	All but $816 a day		$816 a day	$0
	After Day 150	$0		All Medicare-approved amounts for an additional 365 days	$0
Skilled Nursing Home Care	Days 1-20	All costs		$0	$0
	Days 21-100	All but $204 a day		☐ $204 a day **or** ☐ $0 Plan A only	☐ $0 **or** ☐ $204 a day
	After Day 100	$0		$0	All costs
Medical Expenses	Physician's Services in hospital, office, or home; inpatient and outpatient medical services and supplies at a hospital; physical and speech therapy; and ambulance	80% of the Medicare-determined allowable changes after a $240 deductible per calendar year		☐ After $240 Medicare Part B Deductible, 20% of Medicare-approved amounts for Plans A, F, High F, F Plus, G, G Plus, High G, and High G Plus ☐ After $240 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. ☐ $240 Part B deductible for Plans F, High F and F Plus ☐ 100% Part B Excess Charges for Plans F, High F, F Plus, G, G Plus, High G, and High G Plus	Charges not covered by policy and Medicare ☐ $240 Part B deductible for Plans A, G, G Plus, High G, High G Plus, N, and N Plus. ☐ Part B Excess Charges for Plans A, N, and N Plus

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

Date ___/___/___ **Signature of Applicant** X _____

Signature of Producer X _____

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

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

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

BlueCross BlueShield of Illinois

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

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

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

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

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

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

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

☐ Additional benefits.

☐ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment:

_____

☐ Other (please specify): _____

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

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

AGENT'S SIGNATURE	PRINTED NAME OF APPLICANT
PRINTED NAME OF AGENT	APPLICANT'S SIGNATURE
AGENT'S WRITING ID NUMBER	DATE

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

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

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

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

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