BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

Medicare Supplement Insurance Plans

Enroll now – your acceptance is guaranteed![1]

32101.0112

no one handles Medicare coverage gaps better than we do

You're off to a smart start. With this booklet, you're getting important information about Medicare Supplement insurance plans from Blue Cross and Blue Shield of Illinois (BCBSIL).[2]

Information is key to understanding Medicare costs and who covers those costs. For example, while Medicare pays much of your health care bill, you are required to pay what is left over. That could add up quickly – as much as $56,066[3] in a single year.

Choose a Medicare Supplement insurance plan that starts where Medicare stops.

We can help you understand where the gaps in Medicare are and how a Medicare Supplement insurance plan can help you bridge those gaps. And, we'll introduce you to the basic benefits in all nine BCBSIL Medicare Supplement insurance plans. You'll be able to compare options and features from the most basic to the most robust plan – and everything in between. We are confident you will find one that will fit your needs and budget.

[1] As long as you are an Illinois resident, age 65 or older, and have Medicare Parts A and B, your acceptance is guaranteed.

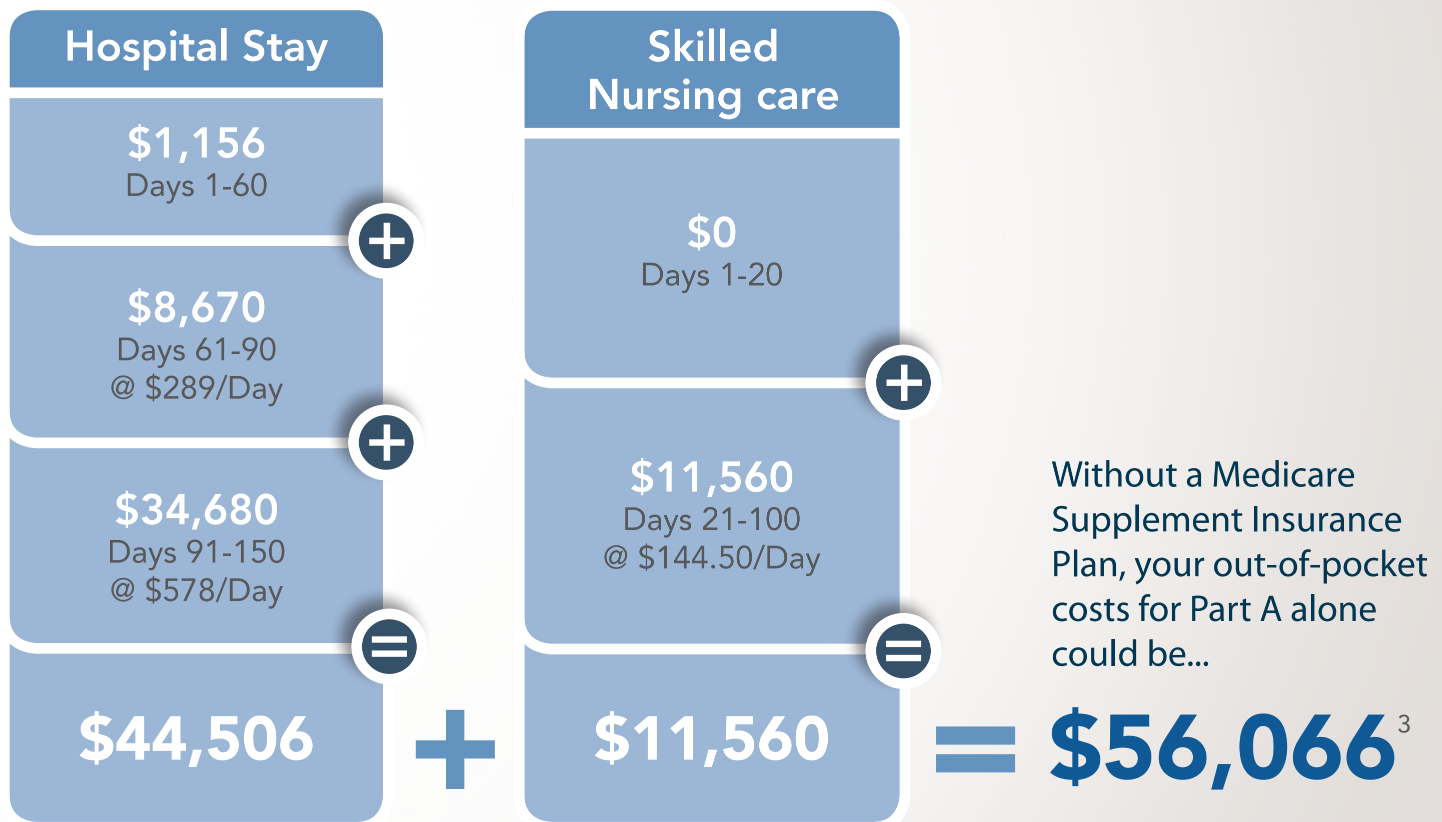
[2] **Not Connected with or Endorsed by the U.S. Government or the Federal Medicare Program.**

[3] Based on an unusual or unique claim.

when Medicare falls short

You can think of Medicare as a safety net. But even a safety net has holes. And when it comes to Medicare, that can leave certain health care expenses uncovered. The cost savings chart below shows what could happen when you have a serious illness or injury without a Medicare Supplement insurance policy to help protect you.

Cost savings chart



Without a Medicare Supplement Insurance Plan, your out-of-pocket costs for Part A alone could be...

$56,066[3]

Medicare Supplement insurance plans to the rescue

Let's start with the basic benefits we include in all our Medicare Supplement insurance plans. These are:

- Part A hospitalization coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Part B medical coinsurance (generally 20 percent of Medicare approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require you to pay a portion of Part B coinsurance or copayments.
- The first three pints of blood each year.
- Hospice Part A coinsurance.

The chart below shows the BCBSIL Medicare Supplement insurance plans that are available to you. As you can see, the plans vary in coverage. This gives you lots of leeway when choosing the right insurance plan for you. To help you decide, talk to one of our BCBSIL Medicare Supplement insurance representatives. You'll get good, sound advice, based on Medicare experience and knowledge. He or she will review your current needs, explain the pros and cons of each plan, and guide you through the selection process. Call today: 1-800-646-3000.

	A	B	C	F|F*	G	K**	L**	N***
Basic Benefits	x	x	x	x	x	x	x	x
Skilled Nursing Co-insurance			x	x	x	x (50%)	x (75%)	x
Part A Deductible		x	x	x	x	x (50%)	x (75%)	x
Part B Deductible			x	x				
Part B Excess				x (100%)	x (100%)			
Foreign Travel Emergency			x	x	x			x
Annual Out-of-Pocket Limit						$4,660****	$2,330****	

beyond the basic

Medicare Supplement insurance coverage

We include plans that can provide you with additional protection. All of these plans – F, High Deductible F, G, and N[4] – offer you:

- **Cost-effective coverage** for many Medicare-eligible expenses, such as:
  - Hospital Care
  - Office Visits/Physician Services
  - Outpatient X-Rays and Lab Tests
  - Physical, Radiation, and Speech Therapy
  - Ambulance Service
- **A name doctors and specialists everywhere know, value, and accept.**

Put your mind at ease knowing that your health care coverage is with a financially stable and recognized leader serving Illinoisans for over 75 years.

[4] We also offer basic Plan A, as well as Plans B, C, K, and L.

* Plan has an option called High Deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year $2,070 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

** Plans K and L provide for different cost-sharing for items and services than the other plans we offer. Once you reach the annual limit, the plan pays 100% of the Medicare copayments and coinsurance for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare approved amounts, called "excess charges". You will be responsible for paying excess charges.

*** Plan N requires a copayment of up to $20 for office visits and a copayment of up to $50 for ER.

**** The out-of-pocket annual limit will increase each year for inflation.

our Medicare Select option[5] can save you money

With Medicare Select, you get the same benefits as our standard Medicare Supplement insurance plans and you reduce your costs. To save on premiums you simply agree to use one of the Medicare Select network hospitals for non-emergency services. Emergency care, however, is covered at any hospital. And, as with all of our Medicare Supplement insurance plans, BCBSIL is recognized by doctors and specialists everywhere. We offer several health care plans that feature Medicare Select. These plans provide a range of benefits and costs. Talk to your BCBSIL Medicare representative to learn more. He or she will be happy to help you select a plan that meets your needs – and saves you money. **Please note: to take part you must live within 30 miles of a network Medicare Select hospital. If you use a non-network hospital for a non-emergency admission, you must pay the $1,156 Part A deductible yourself.**

For the most up-to-date listing of Illinois Medicare Select network hospitals, please visit ***bcbsil.com/over65***.

Need Answers?

Call **1-800-646-3000**.

[5] Med-Select Plans require that you use Blue Cross and Blue Shield of Illinois contracting Med-Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the $1,156 deductible is covered at any hospital from which you receive care.

more valuable features
for plan members

Discount program[6] for health care products and services.

Discounts on the following are available at no extra fee:

- Vision products and services, including eyeware, contact lenses, and laser correction surgery.
- Hearing aids and exams.
- Weight management programs.
- Complementary Alternative Medicine (CAM), including acupuncture, vitamins/herbal supplements, chiropractic, health and wellness-related magazines, and more.

A fitness program[7] that fits your lifestyle.

This program opens the door to a network of fitness centers that are located close to home or work, near friends and family, and even available where you travel. It's never been more convenient and affordable to start your own personal campaign to get and stay in shape. Check out these features – and, for more details, please visit ***bcbsil.com***.

- Virtually unlimited access to a nationwide network of popular fitness clubs.
- Flexible membership, no long-term contracts.
- An affordable one-time enrollment fee and a budget-friendly monthly fee.

[6] The value-added discount program is available to BCBSIL Medicare Supplement insurance members. The products and services available are not part of the Medicare Supplement insurance plan being advertised in this information packet. The discount health care program is not insurance. The value-added products and services may be discontinued or changed at any time and may be subject to geographical availabilities.

[7] The Fitness Program is not part of the Medicare Supplement insurance plan being advertised in this information packet. The Fitness Program may be discontinued or changed at any time and may be subject to geographic availability. Members are responsible for all fees, dues, and other charges related to The Fitness Program. Refer to program terms and conditions for further details.

Take these steps to help protect yourself against uncovered, unexpected medical costs.

- **Use the coverage chart included** to familiarize yourself with BCBSIL Medicare Supplement insurance plans offered. Keep in mind that all plans feature a basic benefits package that covers a significant portion of the Medicare gap.
- **Note the differences between plans.** Some Medicare Supplement insurance plans feature additional coverage options. To help lower costs, some other plans offer lesser benefits or higher cost sharing
- **Consider your situation,** compare plan costs including monthly premium and out-of-pocket-expenses, and apply for the plan that best fits your needs.

Apply now,

send your application today!

we want you to be 100 percent satisfied

We want you to be 100 percent satisfied, and we work hard – very hard – to reach that goal. Maybe that's why our members give us such high "value" ratings. You really do get more for your money from BCBSIL. Remember, to apply you must be a Illinois resident and be covered by Medicare Parts A and B. We look forward to you being our next satisfied subscriber!

Can I change my mind?

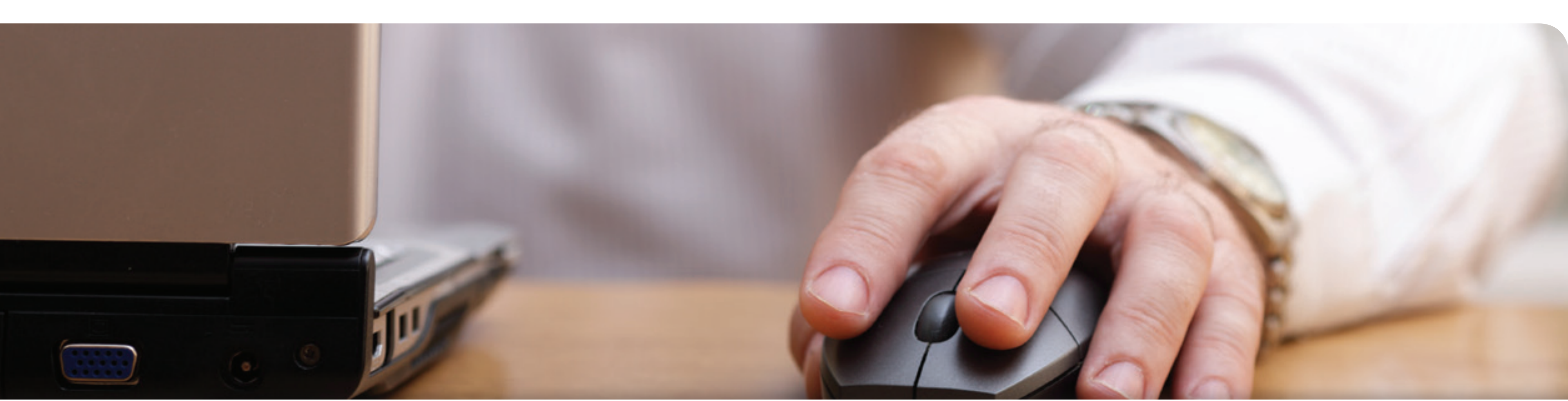
When you apply for a BCBSIL Medicare Supplement insurance plan it is yours to examine without cost or obligation. You don't have to send any money! If coverage is extended, you'll receive your policy package in the mail to examine. When you are satisfied, be sure to pay the first premium to activate your coverage.

If you are not satisfied for any reason, you can follow these simple steps:

Within 30 days after its delivery to you, this policy may be surrendered by delivering or mailing it to the BCBSIL (the Insurer) Administrative Office, branch office, or agent through whom it was purchased. Upon such surrender, any premiums paid – less any claims paid – will be returned.

Ten great reasons to buy a Medicare Supplement insurance plan from BCBSIL.

1. Guaranteed Acceptance.[1]
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 individual service from Medicare Supplement insurance representatives.
6. Coverage when you travel domestically.
7. Online information on claims, benefits, and tools.
8. Over 75 years of experience, know-how, and service to Illinois residents.
9. Discount program that encourages members to experience healthy lifestyles.
10. Easy, online enrollment is available.



Choose from three easy ways to enroll:

Fill out and return the enclosed application.

Call our BCBSIL Medicare Supplement insurance representatives toll-free number **1-800-646-3000**.

Visit our website **bcbsil.com/over65**.

The future is in your hands.

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

Enroll yesterday!

(Today will work too.)

Your acceptance is guaranteed![1]

Call our Medicare Supplement insurance representatives at BCBSIL at **1-800-646-3000**, or visit our website **bcbsil.com/over65**.

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

Medicare Supplement New Business
P.O. Box 3003, Naperville, IL 60566

Application for Medicare Supplement Plan

You may apply for coverage if: ☒ You have Medicare Parts A and B; **AND**, ☒ You are an Illinois resident.

Plan Selection (Select **One**)

Plan A ☐ Standard	**Plan F** ☐ Standard ☐ Med-Select	**Plan K** ☐ Standard ☐ Med-Select
Plan B ☐ Standard ☐ Med-Select	**High Deductible Plan F** ☐ Standard	**Plan L** ☐ Standard ☐ Med-Select
Plan C ☐ Standard ☐ Med-Select	**Plan G** ☐ Standard ☐ Med-Select	**Plan N** ☐ Standard ☐ Med-Select

Policy Effective Date

☐☐ ☐☐ ☐☐☐☐
Month Day Year

Payment Option (Select **One**)

A. Financial Institution Debit Authorization – membership premium **deducted from bank account**:
☐ Monthly Electronic Fund Transfer Account type: ☐ Checking ☐ Savings
Account holder name: ____________________
Bank account number: ____________________ Bank routing number: ____________________
Account Owner Signature (if different than applicant) X ____________________

B. Membership premium **to be billed to my home address** (select one):
☐ Every Two Months ☐ Every Six Months ☐ Once A Year

Applicant Information

First Name	Middle	Last
Mailing Address (Street or P.O. Box, City, State, ZIP+4)		
Gender Male ☐ Female ☐	Date of Birth __ __/__ __/__ __ __ __	Social Security Number __ __ __ – __ __ – __ __ __ __
Residence Phone ( )	Alternate Phone ( )	E-mail Address

Medicare Claim Number

Please copy the Medicare Claim Number from your red, white and blue Medicare Card.

☐☐☐ – ☐☐ – ☐☐☐☐☐

Part A Effective Date __ __/__ __/__ __ __ __

Part B Effective Date __ __/__ __/__ __ __ __

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

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 plans. Please provide a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS

To the best of your knowledge:

Please answer Yes or No

1) Do you meet the eligibility requirements for under age 65 disability? .... ☐ Yes ☐ No

2) Did you turn age 65 in the last 6 months? .... ☐ Yes ☐ No

3) Do you have another Medicare supplement policy in force? .... ☐ Yes ☐ No

a. If yes, with what company, and what plan do you have? (Provide information below)

____

b. If yes, do you intend to replace your current Medicare supplement policy with this policy? .... ☐ Yes ☐ No

4) 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. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? .... ☐ Yes ☐ No

5) a. Have 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**)? .... ☐ Yes ☐ No

If yes, include the effective date: __ __/__ __/__ __ __ __

b. 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

c. Was this your first time in this type of Medicare plan? .... ☐ Yes ☐ No

d. Did you drop a Medicare supplement policy to enroll in the Medicare plan? .... ☐ Yes ☐ No

6) Do you have any other health insurance policies or coverages that provide benefits similar to this Medicare Supplement policy? .... ☐ Yes ☐ No

a. If yes, which company provides the health insurance policies or coverages that provide benefits similar to this Medicare Supplement policy? (Provide information below)

____

b. If yes, what type of policy is it? ☐ Group ☐ Individual ☐ Other (Provide information below)

____

Important Information Regarding Medicare Supplement Coverage

1) You do not need more than one Medicare Supplement policy.

2) Before 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) Benefits and premiums under this policy may be suspended for up to 24 months if you become entitled to benefits under Medicaid. You must request that your policy be suspended within 90 days of becoming entitled to Medicaid. If you lose (are no longer eligible for) benefits from Medicaid, this

policy can be reinstated if you request reinstatement within 90 days of the loss of such benefits and pay the required premium.

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 ninety (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 Medicare Supplement insurance 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 Social Security office. For questions on Medicare Supplement insurance, call 1-800-MEDICARE (1-800-633-4227).

*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.

Acknowledgements and Signature

1) I hereby apply for coverage and request an inspection policy for the Medicare Supplement plan indicated.

2) I understand that once my first premium payment is received, I will be covered as of the date shown on my Blue Cross and Blue Shield of Illinois (hereafter referred to as BCBSIL) 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, are to the best of my knowledge and belief, complete and true, and I agree that BCBSIL believing them to be true shall rely and act upon them accordingly. I hereby agree to furnish any additional information if requested.

4) I acknowledge that I have read and understand the Important Information Regarding Medicare Supplement section regarding Medicare Supplement coverage. If eligible for a Med-Select Plan, I have also read and understand the statements regarding Med-Select as described in the enclosed Outline of Coverage.

Signature Required

Application must be signed and dated to avoid delays in processing. I have read and understand the statements regarding Medicare Supplement coverage. I have received the Outline of Coverage.

Applicant Signature X______________________________ Date Signed: __ __/__ __/__ __ __ __

(Please sign in ink.)

Questions: Call us at our customer service toll-free number 1-800-624-1723, call your insurance agent at the number listed below, or visit www.bcbsil.com.

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.

Primary Applicant's Signature (optional) X ______________________________

Print Your Name as You Signed It: ______________________ Date Signed __ __/__ __/__ __ __ __

Agent Information (if applicable)

The following statements apply if you are purchasing coverage through an agent:

- The undersigned acknowledges that any agent is acting on his/her behalf for the purposes of purchasing the insurance, and that if BCBSIL accepts this application and issues an Individual Policy, BCBSIL may pay the agent a commission and/or other compensation in connection with the issuance of such Individual Policy.
- The undersigned acknowledges that if he/she desires additional information regarding any commissions or other compensation paid the agent by BCBSIL in connection with the issuance of the Individual Policy, he/she should contact the agent.
- The applicant has received a copy of the Medicare Supplement Buyers Guide.

Applicant's Initials ________________

List the following: Any other health insurance policies or coverages sold to the applicant which are still in force:

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

If the applicant is applying for one of the Med-Select contracting Plans, I affirm that I have fully explained to the applicant the requirements of using a Blue Cross and Blue Shield of Illinois contracting Med-Select hospital in order to receive coverage for the Medicare Part A deductible. I have also reaffirmed that the information supplied on this application is accurate and complete.

______________________________ Agent Signature | __ __/__ __/__ __ __ __ Date Signed

______________________________ Print Name of Agent | ______________________________ Agent Code: (SSN or Tax ID Number)

______________________________ Firm's Name (If Applicable) | ______________________________ Agent E-mail Address | (____)________________ Phone Number

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

2012 Policy Checklist

Applicant's Name____

Name of Existing Insurer__________________________ **Expiration Date of Existing Insurance**___/___/___

Medicare Supplement Plans: Important — You **must** indicate your choice of coverage. **Mark only one box, please.**

Plan A ☐ Standard | **Plan C** ☐ Standard ☐ Med-Select | **Plan F** ☐ Standard | **Plan G** ☐ Standard ☐ Med-Select

Plan B ☐ Standard ☐ Med-Select | **Plan F** ☐ Standard ☐ Med-Select | *(High Deductible)*** | **Plan N** ☐ Standard ☐ Med-Select

SERVICE	BENEFIT	MEDICARE PAYS	EXISTING COVERAGE PAYS	SUPPLEMENT COVERS	YOU PAY
HOSPITAL INPATIENT SERVICES	Days 1-60	All but $1,156		☐ $1,156 Part A Deductible* **or** ☐ $0 Plan A Only	☐ $0 **or** ☐ $1,156 Part A Deductible
	Days 61-90	All but $289 a day		$289 a day	$0
	Days 91-150 (Lifetime Reserve)	All but $578 a day		$578 a day	$0
	Days 151 and beyond	$0		All Medicare-approved amounts for an additional 365 days	$0
SKILLED NURSING HOME CARE	Days 1-20 (All Plans)	All costs		$0	$0
	Days 21-100	All but $144.50 a day		☐ $144.50 a day **or** ☐ $0 Plans A, B	☐ $0 **or** ☐ $ 144.50 a day
	Days 101 and beyond (All Plans)	$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 $140 deductible per calendar year		☐ After $140 Medicare Part B Deductible per calendar year, 20% of Medicare-approved amounts for Plans A,B,C,F,High F,G ☐ After $140 Medicare Part B Deductible per calendar year Plan N pays the 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 ☐ $140 Part B deductible for Plans C, F, High F ☐ 100% Part B Excess Charges for Plans F, High F and G	Charges not covered by policy and Medicare ☐ $140 Part B deductible for Plans A, B, G, N ☐ Part B Excess Charges for Plans A, B, C, N
PRESCRIPTION DRUGS		Inpatient Prescription Drugs – 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant		No benefit	All costs; outpatient drugs

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________________________

* Med-Select Plans require that you use Blue Cross and Blue Shield of Illinois participating Med-Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible.

****High Deductible Plan F** offers the same benefits as Plan F after you have paid a $2,070 calendar-year deductible.

BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.®

2012 Policy Checklist

Applicant's Name____

Name of Existing Insurer______________________ **Expiration Date of Existing Insurance**____/____/___

Medicare Supplement Plans: Important — You **must** indicate your choice of coverage. **Mark only one box, please.**

Plan K ☐ Standard ☐ Med-Select
(Annual out-of-pocket limit of $4,660)

Plan L ☐ Standard ☐ Med-Select
(Annual out-of-pocket limit of $2,330)

SERVICE	BENEFIT	MEDICARE PAYS	EXISTING COVERAGE PAYS	SUPPLEMENT COVERS	YOU PAY
HOSPITAL INPATIENT SERVICES	Days 1-60	All but $1,156		Plan K: $578 Part A Deductible* Plan L: $867 Part A Deductible*	☐ Plan K: $578 Part A deductible ☐ Plan L: $289 Part A deductible
	Days 61-90	All but $289 a day		$289 a day	$0
	Days 91-150 (Lifetime Reserve)	All but $578 a day		$578 a day	$0
	Days 151 and beyond	$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 $144.50 a day		☐ Plan K: $72.25 a day ☐ Plan L: $108.38 a day	☐ Plan K: $72.25 a day ☐ Plan L: $36.12 a day
	Days 101 and beyond	$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 $140 deductible per calendar year		☐ After $140 Medicare Calendar Year deductible, Plan K generally pays 10% and Plan L generally pays 15% of Medicare-approved amounts	Charges not covered by policy and Medicare
PRESCRIPTION DRUGS		Inpatient Prescription Drugs – 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant		No benefit	All costs; outpatient drugs

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_______________________________________

* Med-Select Plans require that you use Blue Cross and Blue Shield of Illinois participating Med-Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible.

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

Blue Cross and Blue Shield of Illinois • 300 East Randolph Street • Chicago, IL 60601-5099

SAVE THIS NOTICE!
IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to the information you have furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance 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 INSURANCE PRODUCER

I have reviewed your current medical or health insurance 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 or leave your Medicare Advantage Plan.

The replacement policy is being purchased for the following reason – check one:

- ☐ 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 for disenrollment.
- ☐ Disenrollment from a Medicare Advantage Plan. Please explain reason:________________________
- ☐ 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.

______________________________ Agent's Signature

______________________________ Agent's Number

______________________________ Printed Name and Address of Agent

______________________________ Applicant's Signature

______________________________ Date

OB2207 Rev. 6/05

Note to Producer: You and the applicant who is replacing existing health insurance with Blue Cross and Blue Shield coverage must read, sign and date this replacement form. You must then submit the white copy along with the application. The yellow copy must remain with the applicant.

BlueCross BlueShield of Illinois

Outline of Medicare Supplement Coverage - Standard Benefits for Plans A, B, C, F, High Deductible Plan F*, G, K, L and N

This chart shows the benefits included in each of the standard Medicare supplement plans sold for effective dates on or after June 1, 2010. Every company must make Plan "A" available. Some plans may not be available in Illinois.

BASIC BENEFITS:

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

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B Coinsurance*		Basic, including 100% Part B Coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%.	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B Coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit $4,660; paid at 100% after limit reached	Out-of-pocket limit $2,330; paid at 100% after limit reached		

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year $2,070 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

2012 Monthly Premium Rates

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

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

AGES	OPTION	A	B	C	F	F*	G	K	L	N
Ages 65-66	Standard	$75.00	$123.00	$154.00	$155.00	$51.00	$139.00	$78.00	$112.00	$108.00
Ages 67-69	Standard	$90.00	$143.00	$174.00	$182.00	$59.00	$163.00	$92.00	$131.00	$127.00
Ages 70-74	Standard	$105.00	$173.00	$214.00	$227.00	$72.00	$204.00	$115.00	$163.00	$159.00
Ages 75-79	Standard	$127.00	$214.00	$253.00	$269.00	$86.00	$243.00	$138.00	$194.00	$189.00
Ages 80-84	Standard	$147.00	$250.00	$280.00	$290.00	$93.00	$261.00	$147.00	$209.00	$203.00
Under 65 Disabled/ Ages 85 and Over	Standard	$160.00	$271.00	$305.00	$316.00	$103.00	$284.00	$160.00	$229.00	$221.00

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, 67, 70, 75, 80 and 85. If your premium changes, you will be notified at least 30 days in advance.

*This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year $2,070 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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 Medicare Supplement Membership, P.O. Box 3004, Naperville, IL 60566. 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 has been properly recorded.

Plan A

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

*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.

**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.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION* Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,156	$0	$1,156 (Part A deductible)
61st through 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $578 a day	$578 a day	$0
– Once Lifetime Reserve days are used:			
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three 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 $144.50 a day	$0	Up to $144.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three 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 A

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

*Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan 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 $140 of Medicare-approved amounts*	$0	$0	$140 (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 three pints	$0	All costs	$0
Next $140 of Medicare-approved amounts*	$0	$0	$140 (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 Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $140 of Medicare-approved amounts*	$0	$0	$140 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Plan B

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

*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.

**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.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,156	$1,156 (Part A deductible)	$0
61st through 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $578 a day	$578 a day	$0
– Once Lifetime Reserve days are used:			
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three 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 $144.50 a day	$0	Up to $144.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three 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 B

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

*Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan 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 $140 of Medicare-approved amounts*	$0	$0	$140 (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 three pints	$0	All costs	$0
Next $140 of Medicare-approved amounts*	$0	$0	$140 (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 Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $140 of Medicare-approved amounts*	$0	$0	$140 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Plan C

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

*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.

**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.

Services	Medicare Pays	Plan Pay	You Pay
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,156	$1,156 (Part A deductible)	$0
61st through 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $578 a day	$578 a day	$0
– Once Lifetime Reserve days are used:			
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three 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 $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three 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 C

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

*Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan 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 $140 of Medicare-approved amounts*	$0	$140 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First three pints	$0	All costs	$0
Next $140 of Medicare-approved amounts*	$0	$140 (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 Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $140 of Medicare-approved amounts*	$0	$140 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan 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 F

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

*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.

**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.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,156	$1,156 (Part A deductible)	$0
61st through 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $578 a day	$578 a day	$0
– Once Lifetime Reserve days are used:			
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three 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 $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three 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

*Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan 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 $140 of Medicare-approved amounts*	$0	$140 (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 three pints	$0	All costs	$0
Next $140 of Medicare-approved amounts*	$0	$140 (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 Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $140 of Medicare-approved amounts*	$0	$140 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan 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

High Deductible Plan F

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

*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.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year $2,070 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

***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.

Services	Medicare Pays	After You Pay $2,070 Deductible,** Plan Pays	In Addition To $2,070 Deductible,** You Pay
HOSPITALIZATION* Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,156	$1,156 (Part A deductible)	$0
61st through 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $578 a day	$578 a day	$0
– Once Lifetime Reserve days are used: – Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three 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 $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three 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

* Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	After You Pay $2,070 Deductible,** Plan Pays	In Addition To $2,070 Deductible,** 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 $140 of Medicare-approved amounts*	$0	$140 (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 three pints	$0	All costs	$0
Next $140 of Medicare-approved amounts*	$0	$140 (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 $2,070 Deductible,** Plan Pays	In Addition To $2,070 Deductible,** You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $140 of Medicare-approved amounts*	$0	$140 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	After You Pay $2,070 Deductible,** Plan Pays	In Addition To $2,070 Deductible,** 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 G

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

*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.

**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.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,156	$1,156 (Part A deductible)	$0
61st through 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $578 a day	$578 a day	$0
– Once Lifetime Reserve days are used:			
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three 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 $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three 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

*Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan 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 $140 of Medicare-approved amounts*	$0	$0	$140 (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 three pints	$0	All costs	$0
Next $140 of Medicare-approved amounts*	$0	$0	$140 (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 Pays	You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $140 of Medicare-approved amounts*	$0	$0	$140 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan 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 K

*You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $4,660 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦). Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, the limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "excess charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

**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.

***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.

Services	Medicare Pays	Plan Pays	You Pay*
HOSPITALIZATION**			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,156	$578 (50% of Part A deductible)	$578 (50% of Part A deductible)♦
61st through 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $578 a day	$578 a day	$0
– Once Lifetime Reserve days are used:			
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least three 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 $144.50 a day	Up to $72.25 a day	Up to $72.25 a day♦
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	50%	50%♦
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	50% of Medicare copayment/coinsurance	50% of Medicare copayment/coinsurance♦

Plan K

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

**This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $4,660 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Services	Medicare Pays	Plan 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 $140 of Medicare-approved amounts****	$0	$0	$140 (Part B deductible)****♦
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%♦
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $4,660)**
BLOOD			
First three pints	$0	50%	50%♦
Next $140 of Medicare-approved amounts****	$0	$0	$140 (Part B deductible)♦
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%♦
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan Pays	You Pay*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $140 of Medicare-approved amounts*****	$0	$0	$140 (Part B deductible)♦
Remainder of Medicare-approved amounts	80%	10%	Generally 10%♦

**** Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with asterisks), your Part B deductible will have been met for the calendar year.

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

Plan L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,330 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, the limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "excess charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

**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.

***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.

Services	Medicare Pays	Plan Pays	You Pay*
HOSPITALIZATION**			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,156	$867 (75% of Part A deductible)	$289 (25% of Part A deductible) ♦
61st through 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $578 a day	$578 a day	$0
– Once Lifetime Reserve days are used:			
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least three 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 $144.50 a day	Up to $108.38 a day	Up to $36.12 a day♦
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	75%	25%♦
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	75% of Medicare copayment/coinsurance	25% of Medicare copayment/coinsurance♦

Plan L

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

**This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2,330 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

Services	Medicare Pays	Plan 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 $140 of Medicare-approved amounts****	$0	$0	$140 (Part B deductible)****♦
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $2,330)**
BLOOD			
First three pints	$0	75%	25%♦
Next $140 of Medicare-approved amounts****	$0	$0	$140 (Part B deductible)♦
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan Pays	You Pay*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $140 of Medicare-approved amounts*****	$0	$0	$140 (Part B deductible)♦
Remainder of Medicare-approved amounts	80%	15%	Generally 5%♦

**** Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with asterisks), your Part B deductible will have been met for the calendar year.

***** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare.*

Plan N

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

*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.

**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.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,156	$1,156 (Part A deductible)	$0
61st through 90th day	All but $289 a day	$289 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $578 a day	$578 a day	$0
– Once Lifetime Reserve days are used:			
– Additional 365 days	$0	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least three 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 $144.50 a day	Up to $144.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three 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

* Once you have been billed $140 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan 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 $140 of Medicare-approved amounts*	$0	$0	$140 (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 three pints	$0	All costs	$0
Next $140 of Medicare-approved amounts*	$0	$0	$140 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $140 of Medicare-approved amounts*	$0	$0	$140 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Plan N

MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan Pays	You Pay
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

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