BlueCross BlueShield of Illinois

Outline of Medicare Supplement Coverage — Standard Benefits for Plan A and High Deductible Plan F* and Standard and Medicare Select Benefits for Plans B, C, 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. Blue Cross and Blue Shield of Illinois does not offer those plans shaded in gray below.

BASIC BENEFITS:

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

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 $4,940; paid at 100% after limit reached	Out-of-pocket limit $2,470; 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 $2,180 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,180. 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.

Medicare Select Plans require that you use Blue Cross and Blue Shield of Illinois contracting Medicare Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency the $1,260 deductible is covered at any hospital from which you receive care.

Monthly Premium Rates effective January 1, 2015

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.

AGE	OPTION	A	B	C	F	High Deductible Plan F*	G	K	L	N
Age U65	Standard	167.00	284.00	320.00	331.00	107.00	297.00	167.00	240.00	232.00
	Medicare Select	N/A	221.00	239.00	262.00	N/A	235.00	147.00	200.00	184.00
Age 65	Standard	72.00	119.00	148.00	149.00	48.00	134.00	75.00	108.00	105.00
	Medicare Select	N/A	101.00	127.00	134.00	N/A	123.00	71.00	103.00	95.00
Age 66	Standard	76.00	124.00	154.00	156.00	51.00	140.00	79.00	113.00	109.00
	Medicare Select	N/A	105.00	132.00	142.00	N/A	128.00	76.00	108.00	100.00
Age 67	Standard	82.00	131.00	162.00	166.00	54.00	149.00	85.00	120.00	116.00
	Medicare Select	N/A	112.00	142.00	153.00	N/A	140.00	84.00	117.00	108.00
Age 68	Standard	88.00	140.00	169.00	177.00	57.00	159.00	90.00	127.00	124.00
	Medicare Select	N/A	119.00	151.00	165.00	N/A	150.00	91.00	126.00	117.00
Age 69	Standard	92.00	146.00	178.00	187.00	60.00	168.00	95.00	135.00	131.00
	Medicare Select	N/A	124.00	156.00	172.00	N/A	155.00	95.00	131.00	121.00
Age 70	Standard	95.00	153.00	187.00	199.00	63.00	178.00	101.00	143.00	139.00
	Medicare Select	N/A	129.00	162.00	179.00	N/A	161.00	98.00	137.00	124.00
Age 71	Standard	99.00	161.00	199.00	210.00	67.00	188.00	106.00	150.00	146.00
	Medicare Select	N/A	135.00	168.00	185.00	N/A	165.00	102.00	142.00	129.00
Age 72	Standard	103.00	168.00	209.00	221.00	70.00	200.00	112.00	159.00	155.00
	Medicare Select	N/A	142.00	174.00	192.00	N/A	172.00	106.00	146.00	133.00

AGE	OPTION	A	B	C	F	High Deductible Plan F*	G	K	L	N
Age 73	Standard	108.00	178.00	219.00	233.00	74.00	210.00	118.00	166.00	162.00
	Medicare Select	N/A	148.00	181.00	200.00	N/A	179.00	110.00	152.00	140.00
Age 74	Standard	113.00	188.00	229.00	243.00	78.00	219.00	124.00	174.00	170.00
	Medicare Select	N/A	154.00	186.00	207.00	N/A	184.00	114.00	157.00	144.00
Age 75	Standard	117.00	196.00	236.00	250.00	80.00	225.00	127.00	180.00	175.00
	Medicare Select	N/A	158.00	190.00	211.00	N/A	188.00	117.00	160.00	147.00
Age 76	Standard	121.00	202.00	241.00	256.00	83.00	231.00	130.00	183.00	179.00
	Medicare Select	N/A	162.00	192.00	214.00	N/A	191.00	118.00	162.00	150.00
Age 77	Standard	124.00	209.00	247.00	262.00	85.00	237.00	134.00	188.00	183.00
	Medicare Select	N/A	164.00	195.00	217.00	N/A	194.00	120.00	164.00	152.00
Age 78	Standard	128.00	218.00	255.00	269.00	86.00	242.00	137.00	194.00	188.00
	Medicare Select	N/A	171.00	200.00	220.00	N/A	195.00	122.00	165.00	153.00
Age 79	Standard	132.00	224.00	259.00	273.00	88.00	246.00	139.00	197.00	192.00
	Medicare Select	N/A	176.00	201.00	221.00	N/A	197.00	123.00	167.00	154.00
Age 80	Standard	137.00	231.00	265.00	276.00	89.00	250.00	141.00	200.00	195.00
	Medicare Select	N/A	181.00	202.00	222.00	N/A	198.00	124.00	168.00	154.00
Age 81	Standard	140.00	236.00	267.00	278.00	90.00	251.00	142.00	201.00	196.00
	Medicare Select	N/A	184.00	202.00	222.00	N/A	199.00	124.00	169.00	155.00
Age 82	Standard	143.00	243.00	273.00	282.00	91.00	255.00	143.00	204.00	199.00
	Medicare Select	N/A	189.00	204.00	223.00	N/A	200.00	124.00	170.00	156.00
Age 83	Standard	146.00	249.00	278.00	289.00	93.00	260.00	146.00	209.00	202.00
	Medicare Select	N/A	193.00	209.00	229.00	N/A	204.00	127.00	174.00	160.00

AGE	OPTION	A	B	C	F	High Deductible Plan F*	G	K	L	N
Age 84	Standard	150.00	254.00	285.00	295.00	96.00	266.00	150.00	214.00	207.00
	Medicare Select	N/A	199.00	213.00	234.00	N/A	209.00	130.00	178.00	163.00
Age 85	Standard	153.00	259.00	291.00	301.00	98.00	272.00	153.00	219.00	212.00
	Medicare Select	N/A	202.00	218.00	238.00	N/A	214.00	133.00	181.00	168.00
Age 86	Standard	156.00	265.00	297.00	308.00	100.00	277.00	156.00	224.00	216.00
	Medicare Select	N/A	206.00	222.00	244.00	N/A	219.00	138.00	186.00	172.00
Age 87	Standard	160.00	271.00	304.00	314.00	103.00	283.00	160.00	229.00	220.00
	Medicare Select	N/A	211.00	228.00	249.00	N/A	223.00	141.00	190.00	176.00
Age 88	Standard	161.00	272.00	305.00	315.00	103.00	284.00	161.00	230.00	221.00
	Medicare Select	N/A	212.00	229.00	250.00	N/A	224.00	142.00	191.00	177.00
Age 89	Standard	161.00	273.00	307.00	317.00	104.00	285.00	161.00	231.00	222.00
	Medicare Select	N/A	213.00	230.00	251.00	N/A	225.00	142.00	192.00	177.00
Age 90	Standard	162.00	274.00	308.00	318.00	104.00	287.00	162.00	232.00	223.00
	Medicare Select	N/A	214.00	231.00	252.00	N/A	227.00	143.00	192.00	178.00
Age 91	Standard	162.00	276.00	309.00	320.00	105.00	288.00	162.00	233.00	224.00
	Medicare Select	N/A	215.00	232.00	253.00	N/A	228.00	143.00	193.00	179.00
Age 92	Standard	162.00	276.00	311.00	322.00	105.00	289.00	162.00	234.00	225.00
	Medicare Select	N/A	215.00	233.00	254.00	N/A	229.00	143.00	194.00	180.00
Age 93	Standard	163.00	277.00	312.00	323.00	105.00	290.00	163.00	235.00	226.00
	Medicare Select	N/A	216.00	234.00	255.00	N/A	230.00	144.00	195.00	180.00

AGE	OPTION	A	B	C	F	High Deductible Plan F*	G	K	L	N
Age 94	Standard	164.00	278.00	313.00	324.00	105.00	292.00	164.00	236.00	227.00
	Medicare Select	N/A	217.00	235.00	256.00	N/A	231.00	144.00	197.00	181.00
Age 95	Standard	165.00	279.00	314.00	326.00	106.00	293.00	165.00	237.00	228.00
	Medicare Select	N/A	218.00	236.00	257.00	N/A	232.00	145.00	197.00	181.00
Age 96	Standard	165.00	281.00	315.00	327.00	106.00	294.00	165.00	238.00	229.00
	Medicare Select	N/A	219.00	237.00	258.00	N/A	232.00	145.00	198.00	182.00
Age 97	Standard	166.00	282.00	316.00	329.00	106.00	295.00	166.00	238.00	230.00
	Medicare Select	N/A	219.00	238.00	260.00	N/A	233.00	146.00	199.00	182.00
Age 98	Standard	167.00	283.00	318.00	330.00	107.00	296.00	167.00	239.00	231.00
	Medicare Select	N/A	220.00	238.00	261.00	N/A	234.00	147.00	200.00	183.00
Age 99	Standard	167.00	284.00	320.00	331.00	107.00	297.00	167.00	240.00	232.00
	Medicare Select	N/A	221.00	239.00	262.00	N/A	235.00	147.00	200.00	184.00
Age 100+	Standard	167.00	284.00	320.00	331.00	107.00	297.00	167.00	240.00	232.00
	Medicare Select	N/A	221.00	239.00	262.00	N/A	235.00	147.00	200.00	184.00

You have the option to purchase any of the Medicare Supplement benefit plans shown on the front cover in white as Standard Plans or as Medicare Select Plans, with the exception of Plan A and High Deductible Plan F,* which are available as **Standard Plans only**. Medicare Select Plans require that you use a Blue Cross and Blue Shield of Illinois contracting Medicare Select hospital for non-emergency admissions to receive coverage for the Medicare Part A deductible.

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.

***This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,180 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,180. 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.

MEDICARE SELECT ADDITIONAL DISCLOSURES

GRIEVANCE PROCEDURES

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

If you have any dissatisfaction with your Medicare Select coverage, please send all written grievances within 60 days of the occurrence of your dissatisfaction to: **Medicare Supplement Grievance Committee, PO Box 3122, Naperville, IL 60566-9744 or fax (888) 235-2936.**

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

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

QUALITY ASSURANCE

As part of our Quality Assurance program, all contracted hospitals must meet Medicare standards. In addition, hospitals must meet the contract criteria stated in the Hospital Agreement.

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

MEDICARE SELECT HOSPITAL RESTRICTIONS

Plans B, C, F, G, K, L and N are Medicare Select policies currently available. Part A benefits may be restricted if you receive services in a hospital that is not a Medicare Select Hospital.

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

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

Plan A

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

***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.**

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$0	$1,260 (Part A deductible)
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 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 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 $157.50 a day	$0	Up to $157.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

****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

*** Once you have been billed $147 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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (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.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$1,260 (Part A deductible)[1]	$0
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 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 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 $157.50 a day	$0	Up to $157.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

[1] Medicare Select Plans require that you use Blue Cross and Blue Shield of Illinois contracting Medicare Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the $1,260 deductible is covered at any hospital from which you receive care.

**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 B

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

* Once you have been billed $147 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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (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.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$1,260 (Part A deductible)[1]	$0
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 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 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 $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

[1] Medicare Select Plans require that you use Blue Cross and Blue Shield of Illinois contracting Medicare Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the $1,260 deductible is covered at any hospital from which you receive care.

**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 C

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

* Once you have been billed $147 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 $147 of Medicare-approved amounts*	$0	$147 (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 3 pints	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGONOSTIC 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 $147 of Medicare-approved amounts*	$0	$147 (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

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.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$1,260 (Part A deductible)[1]	$0
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 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 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 $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

[1] Medicare Select Plans require that you use Blue Cross and Blue Shield of Illinois contracting Medicare Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the $1,260 deductible is covered at any hospital from which you receive care.

**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 F

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

* Once you have been billed $147 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 $147 of Medicare-approved amounts*	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$147 (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

*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 $2,180 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,180. 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.

Services	Medicare Pays	After You Pay $2,180 Deductible**, Plan Pays	In addition To $2,180 Deductible**, You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$1,260 (Part A deductible)	$0
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 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 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 $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

***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.

High Deductible Plan F

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

* Once you have been billed $147 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 $2,180 Deductible**, Plan Pays	In addition To $2,180 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 $147 of Medicare-approved amounts*	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$147 (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 $2,180 Deductible**, Plan Pays	In addition To $2,180 Deductible**, You Pay
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $147 of Medicare-approved amounts*	$0	$147 (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 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.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$1,260 (Part A deductible)[1]	$0
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 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 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 $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

[1] Medicare Select Plans require that you use Blue Cross and Blue Shield of Illinois contracting Medicare Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the $1,260 deductible is covered at any hospital from which you receive care.

**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 G

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

* Once you have been billed $147 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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 K

* You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $4,940 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.

Services	Medicare Pays	Plan Pays	You Pay*
HOSPITALIZATION**			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$630 (50% of Part A deductible)[1]	$630 (50% of Part A deductible)♦
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 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 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 $157.50 a day	Up to $78.75 a day	Up to $78.75 a day♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 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♦

[1] Medicare Select Plans require that you use Blue Cross and Blue Shield of Illinois contracting Medicare Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, 50% of the $1,260 deductible is covered at any hospital from which you receive care.

***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 K

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

† This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $4,940 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 $147 of Medicare-approved amounts****	$0	$0	$147 (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 $4,940)†
BLOOD			
First 3 pints	$0	50%	50%◆
Next $147 of Medicare-approved amounts****	$0	$0	$147 (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 $147 of Medicare-approved amounts*****	$0	$0	$147 (Part B deductible)◆
Remainder of Medicare-approved amounts	80%	10%	Generally 10%◆

**** Once you have been billed $147 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 $2,470 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.

Services	Medicare Pays	Plan Pays	You Pay*
HOSPITALIZATION**			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$945 (75% of Part A deductible)[1]	$315 (25% of Part A deductible)♦
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 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 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 $157.50 a day	Up to $118.13 a day	Up to $39.37 a day♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 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♦

[1] Medicare Select Plans require that you use Blue Cross and Blue Shield of Illinois contracting Medicare Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, 75% of the $1,260 deductible is covered at any hospital from which you receive care.

***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 L

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

† This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2,470 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 $147 of Medicare-approved amounts****	$0	$0	$147 (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 $2,470)†
BLOOD			
First 3 pints	$0	75%	25%◆
Next $147 of Medicare-approved amounts****	$0	$0	$147 (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 $147 of Medicare-approved amounts*****	$0	$0	$147 (Part B deductible)◆
Remainder of Medicare-approved amounts	80%	15%	Generally 5%◆

**** Once you have been billed $147 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.

Services	Medicare Pays	Plan Pays	You Pay
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,260	$1,260 (Part A deductible)[1]	$0
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $630 a day	$630 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 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 $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

[1] Medicare Select Plans require that you use Blue Cross and Blue Shield of Illinois contracting Medicare Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible. In an emergency, the $1,260 deductible is covered at any hospital from which you receive care.

**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 N

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

* Once you have been billed $147 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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Plan N

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 $147 of Medicare-approved amounts*	$0	$0	$147 (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

BlueCross BlueShield of Illinois