



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 \$1,132		<input type="checkbox"/> \$1,132 Part A Deductible* or <input type="checkbox"/> \$0 Plan A Only	<input type="checkbox"/> \$0 or <input type="checkbox"/> \$1,132 Part A Deductible
	Days 61-90	All but \$283 a day		\$283 a day	\$0
	Days 91-150 (Lifetime Reserve)	All but \$566 a day		\$566 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 \$141.50 a day		<input type="checkbox"/> \$141.50 a day or <input type="checkbox"/> \$0 Plans A, B	<input type="checkbox"/> \$0 or <input type="checkbox"/> \$ 141.50 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 charges after a \$162 deductible per calendar year		<input type="checkbox"/> After \$162 Medicare Part B Deductible per calendar year, 20% of Medicare-approved amounts for Plans A,B,C,F,High F,G <input type="checkbox"/> After \$162 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 <input type="checkbox"/> \$162 Part B deductible for Plans C, F, High F <input type="checkbox"/> 100% Part B Excess Charges for Plans F, High F and G	Charges not covered by policy and Medicare <input type="checkbox"/> \$162 Part B deductible for Plans A, B, G, N <input type="checkbox"/> 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 \$2,000 calendar-year deductible.