Blue Cross and Blue Shield of Illinois

Outline of Medicare Supplement Coverage — Standard and Med-Select Benefit Plans B, C, D, E, F, High Deductible Plan F*, K and L

Medicare Supplement insurance can be sold in only 12 standard plans, plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A." Blue Cross and Blue Shield of Illinois does not offer those plans shaded in gray below.

BASIC BENEFITS: Included in all plans. Plans K and L include benefits at different levels of cost sharing.
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 in the case of hospital outpatient department services under a prospective payment system, applicable copayments.
Blood: First three pints of blood each year.

	A	B	C	D	E	F	F*	G	H	I	J	J*	K**	L**
Basic Benefits	X	X	X	X	X	X		X	X	X	X		X	X
Skilled Nursing Coinsurance			X	X	X	X		X	X	X	X		X (50%)	X (75%)
Part A Deductible		X	X	X	X	X		X	X	X	X		X (50%)	X (75%)
Part B Deductible			X			X					X			
Part B Excess						X (100%)		X (80%)		X (100%)	X (100%)			
Foreign Travel Emergency			X	X	X	X		X	X	X	X			
At-Home Recovery				X				X		X	X			
Preventive Care					X						X			
Annual Out-of-Pocket Limit													$4,440***	$2,220***

Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J.* These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar-year $1,900 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are $1,900. 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 plans' separate foreign travel emergency deductible.

**Plans K and L provide for different cost-sharing for items and services from Plans A-J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance and deductibles 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.

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

2008 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 contact your Blue Cross and Blue Shield of Illinois insurance representative.

AGES	OPTION	C	D	E	F	F*	K	L
Ages 65-66	Standard	$147.00	$125.00	$129.00	$149.00	$48.00	$75.00	$107.00
	Med-Select	$121.00	$105.00	$109.00	$128.00	N/A	$70.00	$98.00
Ages 67-69	Standard	$160.00	$139.00	$146.00	$166.00	$54.00	$85.00	$120.00
	Med-Select	$136.00	$117.00	$120.00	$150.00	N/A	$83.00	$114.00
Ages 70-74	Standard	$188.00	$163.00	$169.00	$200.00	$64.00	$101.00	$144.00
	Med-Select	$152.00	$131.00	$141.00	$167.00	N/A	$93.00	$127.00
Ages 75-79	Standard	$222.00	$201.00	$208.00	$237.00	$76.00	$121.00	$171.00
	Med-Select	$170.00	$158.00	$162.00	$188.00	N/A	$103.00	$144.00
80 and Over	Standard	$242.00	$232.00	$238.00	$251.00	$81.00	$127.00	$181.00
	Med-Select	$174.00	$179.00	$189.00	$191.00	N/A	$106.00	$146.00

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 this state. We will not change your premium or cancel your policy because of poor health. Premiums change at age 67, 70, 75 and 80. If your premium changes, you will be notified at least 30 days in advance.

Rates for **Plan A****: ages 65-66: Standard $72.00,
ages 67-69: Standard $83.00,
ages 70-74: Standard $93.00,
ages 75-79: Standard $112.00,
ages 80+: Standard $127.00.

***Med-Select option not available under Plan A*

Rates for **Plan B**: ages 80+: Standard $219.00.
Med-Select $164.00.

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 Med-Select Plans, with the exception of Plan A and High Deductible Plan F,* which are available as **Standard Plans only.** Med-Select Plans require that you use a Blue Cross and Blue Shield of Illinois contracting Med-Select hospital for non-emergency admissions to receive coverage for the Medicare Part A deductible.

*This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year $1,900 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $1,900. 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.

BlueCross BlueShield of Texas

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 B COVERS	WITH PLAN B YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,024	$1,024 (Part A deductible)**	$0
61st through 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $512 a day	$512 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 $128 a day	$0	Up to $128 a day
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0

**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 $1,024 deductible is covered at any hospital from which you receive care.

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD (continued)			
SERVICES	MEDICARE PAYS	PLAN B COVERS	WITH PLAN B YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR *Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with a single asterisk), your Part B deductible will have been met for the calendar year.			
SERVICES	MEDICARE PAYS	PLAN B COVERS	WITH PLAN B YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $135 of Medicare-approved amounts*	$0	$0	$135 (Part B deductible)
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	$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 $135 of Medicare-approved amounts*	$0	$0	$135 (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 B COVERS	WITH PLAN B YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment First $135 of Medicare-approved amounts*	$0	$0	$135 (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 C COVERS	WITH PLAN C YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,024	$1,024 (Part A deductible)**	$0
61st through 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $512 a day	$512 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 $128 a day	Up to $128 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0

**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 $1,024 deductible is covered at any hospital from which you receive care.

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD (continued)			
SERVICES	MEDICARE PAYS	PLAN C COVERS	WITH PLAN C YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR *Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with a single asterisk), your Part B deductible will have been met for the calendar year.			
SERVICES	MEDICARE PAYS	PLAN C COVERS	WITH PLAN C YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $135 of Medicare-approved amounts*	$0	$135 (Part B deductible)	$0
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	$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 $135 of Medicare-approved amounts*	$0	$135 (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 C COVERS	WITH PLAN C YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment First $135 of Medicare-approved amounts*	$0	$135 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	PLAN C COVERS	WITH PLAN C 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 D

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 D COVERS	WITH PLAN D YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,024	$1,024 (Part A deductible)**	$0
61st through 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $512 a day	$512 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 $128 a day	Up to $128 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0

**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 $1,024 deductible is covered at any hospital from which you receive care.

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD (continued)			
SERVICES	MEDICARE PAYS	PLAN D COVERS	WITH PLAN D YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR *Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with a single asterisk), your Part B deductible will have been met for the calendar year.			
SERVICES	MEDICARE PAYS	PLAN D COVERS	WITH PLAN D YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $135 of Medicare-approved amounts*	$0	$0	$135 (Part B deductible)
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	$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 $135 of Medicare-approved amounts*	$0	$0	$135 (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 D COVERS	WITH PLAN D YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment First $135 of Medicare-approved amounts*	$0	$0	$135 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a home care treatment plan			
– Benefit for each visit	$0	Actual charges to $40 a visit	Balance
– Number of visits covered (must be received within eight weeks of last Medicare-approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed seven each week	
– Calendar-year maximum	$0	$1,600	

OTHER BENEFITS – NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	PLAN D COVERS	WITH PLAN D 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 E

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 E COVERS	WITH PLAN E YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,024	$1,024 (Part A deductible)**	$0
61st through 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $512 a day	$512 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 $128 a day	Up to $128 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0

**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 $1,024 deductible is covered at any hospital from which you receive care.

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD (continued)			
SERVICES	MEDICARE PAYS	PLAN E COVERS	WITH PLAN E YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR *Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with a single asterisk), your Part B deductible will have been met for the calendar year.			
SERVICES	MEDICARE PAYS	PLAN E COVERS	WITH PLAN E YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $135 of Medicare-approved amounts*	$0	$0	$135 (Part B deductible)
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	$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 $135 of Medicare-approved amounts*	$0	$0	$135 (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 E COVERS	WITH PLAN E YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment First $135 of Medicare-approved amounts*	$0	$0	$135 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE *Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.			
SERVICES	MEDICARE PAYS	PLAN E COVERS	WITH PLAN E 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
*PREVENTIVE MEDICAL CARE BENEFIT NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

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 F COVERS	WITH PLAN F YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,024	$1,024 (Part A deductible)**	$0
61st through 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $512 a day	$512 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 $128 a day	Up to $128 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0

**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 $1,024 deductible is covered at any hospital from which you receive care.

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD (continued)			
SERVICES	MEDICARE PAYS	PLAN F COVERS	WITH PLAN F YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR *Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with a single asterisk), your Part B deductible will have been met for the calendar year.			
SERVICES	MEDICARE PAYS	PLAN F COVERS	WITH PLAN F YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $135 of Medicare-approved amounts*	$0	$135 (Part B deductible)	$0
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	$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 $135 of Medicare-approved amounts*	$0	$135 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN F COVERS	WITH PLAN F YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment First $135 of Medicare-approved amounts*	$0	$135 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	PLAN F COVERS	WITH PLAN F 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.

‡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 F† COVERS	WITH PLAN F† YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,024	$1,024 (Part A deductible)	$0
61st through 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $512 a day	$512 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 $128 a day	Up to $128 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	Three pints	$0
Additional amounts	100%	$0	$0

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD (continued)			
SERVICES	MEDICARE PAYS	PLAN F† COVERS	WITH PLAN F† YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR *Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with a single asterisk), your Part B deductible will have been met for the calendar year.			
SERVICES	MEDICARE PAYS	PLAN F† COVERS	WITH PLAN F† YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $135 of Medicare-approved amounts*	$0	$135 (Part B deductible)	$0
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	$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 $135 of Medicare-approved amounts*	$0	$135 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN F† COVERS	WITH PLAN F† YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment First $135 of Medicare-approved amounts*	$0	$135 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	PLAN F† COVERS	WITH PLAN F† 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

†This high deductible plan pays the same benefits as Plan F after one has paid a calendar-year $1,900 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $1,900. 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.

Plan K

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.

♦You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $4,440 each calendar year. The amounts that count toward your annual limit are noted with (♦).

‡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 K COVERS	WITH PLAN K YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,024	$512 (50% of Part A deductible)**	$512♦ (50% of Part A deductible)**
61st through 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $512 a day	$512 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 $128 a day	Up to $64 a day	Up to $64 a day♦
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	50%	50%♦
Additional amounts	100%	$0	$0

**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, 50% of the $1,024 deductible is covered at any hospital from which you receive care.

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD (continued)			
SERVICES	MEDICARE PAYS	PLAN K COVERS	WITH PLAN K YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments♦

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

*Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with a single asterisk), your Part B deductible will have been met for the calendar year.

♦You will pay half of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $4,440 each calendar year. The amounts that count toward your annual limit are noted with (♦).

SERVICES	MEDICARE PAYS	PLAN K COVERS	WITH PLAN K YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $135 of Medicare-approved amounts*	$0	$0	$135 (Part B deductible)♦
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 10%	Generally 10%♦
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First three pints	$0	50%	50%♦
Next $135 of Medicare-approved amounts*	$0	$0	$135 (Part B deductible)♦
Remainder of Medicare-approved amounts	80%	Generally 10%	Generally 10%♦
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN K COVERS	WITH PLAN K YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment First $135 of Medicare-approved amounts*	$0	$0	$135 (Part B deductible)♦
Remainder of Medicare-approved amounts	80%	10%	10%♦

OTHER BENEFITS – NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	PLAN K COVERS	WITH PLAN K 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	$0	All costs

PLAN L

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.

♦♦You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,220 each calendar year. The amounts that count toward your annual limit are noted with (♦♦).

‡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 L COVERS	WITH PLAN L YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,024	$768 (75% of Part A deductible)**	$256♦♦ (25% of Part A deductible)**
61st through 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $512 a day	$512 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 $128 a day	Up to $96 a day	Up to $32 a day♦♦
101st day and after	$0	$0	All costs
BLOOD			
First three pints	$0	75%	25%♦♦
Additional amounts	100%	$0	$0

**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, 75% of the $1,024 deductible is covered at any hospital from which you receive care.

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD (continued)			
SERVICES	MEDICARE PAYS	PLAN L COVERS	WITH PLAN L YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments♦♦

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
*Once you have been billed $135 of Medicare-approved amounts for covered services (which are noted with a single asterisk), your Part B deductible will have been met for the calendar year. ♦♦You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,220 each calendar year. The amounts that count toward your annual limit are noted with (♦♦).			
SERVICES	MEDICARE PAYS	PLAN L COVERS	WITH PLAN L YOU PAY
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $135 of Medicare-approved amounts*	$0	$0	$135 (Part B deductible)♦♦
Preventive benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%♦♦
PART B EXCESS CHARGES (above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First three pints	$0	75%	25%♦♦
Next $135 of Medicare-approved amounts*	$0	$0	$135 (Part B deductible)♦♦
Remainder of Medicare-approved amounts	80%	Generally 15%	Generally 5%♦♦
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

MEDICARE (PARTS A & B)			
SERVICES	MEDICARE PAYS	PLAN L COVERS	WITH PLAN L YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment First $135 of Medicare-approved amounts*	$0	$0	$135 (Part B deductible)♦♦
Remainder of Medicare-approved amounts	80%	15%	5%♦♦

OTHER BENEFITS – NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	PLAN L COVERS	WITH PLAN L 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	$0	All costs

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

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

RIGHT TO RETURN YOUR POLICY
If you find that you are not satisfied with your policy, you may return it to Blue Cross and Blue Shield of Illinois, P.O. Box 806162, Chicago, IL 60680-4123. 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. Blue Cross and Blue Shield of Illinois is not 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.

MED-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 Med-Select coverage, please send all written grievances within 60 days of the occurrence of your dissatisfaction to: Blue Cross and Blue Shield of Illinois, Medicare Select Program, P.O. Box 1637, Chicago, Illinois 60690-1637.

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.

MED-SELECT HOSPITAL RESTRICTIONS
Plans B, C, D, E, F, K and L are Med-Select policies currently available. Part A benefits may be restricted if you receive services in a hospital that is not a Med-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 Med-Select Hospital (such as while you are traveling); or
3. Covered services are not available through a Med-Select Hospital.

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