

<ul style="list-style-type: none"> • Prenotification/Pre-certification is not required for these groups. • If Medicare denies, BCBSIL will also deny the services. 		Group Number 69941	Group Number 69942	Group Number 69953	Group Number 69943	Group Number 69944	Group Number 69945	Group Number 69975
2006 BENEFITS								
MEDICARE PART A: I/P HOSPITAL	MEDICARE PAYS							
1st through 60th Day	All but \$952	Nothing	\$952	\$952	\$952	\$952	\$952	\$952*
61st through 90th Day	All but \$238/day	\$238/day	\$238/day	\$238/day	\$238/day	\$238/day	\$238/day	\$238/day*
91st through 150th Day	All but \$476/day	\$476/day	\$476/day	\$476/day	\$476/day	\$476/day	\$476/day	\$476/day*
151st through 365th Day	Nothing	100% ME	100% M/E	100% M/E	100% M/E	100% M/E	100% M/E	100% M/E*
366th through 515th Day	Nothing	100% ME	100% M/E	100% M/E	100% M/E	100% M/E	100% M/E	100% M/E*
516th through 820th Day	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
SNF 1st through 20th Day	100% M/E	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
SNF 21st through 100th Day	All but \$119/day	Nothing	Nothing	\$119/day	\$119/day	\$119/day	\$119/day	\$119/day*
SNF 101st through 365th Day	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
BLOOD: PARTS A & B	All but first 3 pts.	First 3 pts.	First 3 pts.	First 3 pts.	First 3 pts.	First 3 pts.	First 3 pts.	First 3 pts. *
MEDICARE PART B: PHYSICIAN								
\$124 Medicare Deductible	Nothing	Nothing	Nothing	\$124	Nothing	Nothing	\$124	\$124*
BCBSI Deductible	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	\$1790
Part B Excess Charges	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	100%	100%*
Inpatient Physician	80% M/E	20% M/E	20% M/E	20% M/E	20% M/E	20% M/E	20% M/E	20% M/E*
Outpatient Hospital	80% M/E	20% M/E	20% M/E	20% M/E	20% M/E	20% M/E	20% M/E	20% M/E*
Private Duty Nursing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
Medical Supplies, Speech/Physical Therapy, Ambulance, Diagnostic Lab, Xray, Home/Office Visits, Durable Equipment, Prosthetics	80% M/E	20% M/E	20% M/E	20% M/E	20% M/E	20% M/E	20% M/E	20% M/E*
Prescription Drugs	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing	Nothing
Foreign Country	Nothing	Nothing	Nothing	**	**	**	**	**
At-Home Care	Nothing	Nothing	Nothing	Nothing	***	Nothing	Nothing	Nothing
Preventive Medical Care (Non-Medicare Approved)	Nothing	Nothing	Nothing	Nothing	Nothing	100% up to \$120/yr	Nothing	Nothing
Preventive Medical Care (Medicare Approved)	75% M/E	Remaining Med App Amt	Remaining Med App Amt	Remaining Med App Amt	Remaining Med App Amt	Remaining Med App Amt	Remaining Med App Amt	Remaining Med App Amt
Inpatient / Outpatient Psychiatric Care	50% M/E	50% M/E	50% M/E	50% M/E	50% M/E	50% M/E	50% M/E	50% M/E*

M/E = MEDICARE ELIGIBLE E/C = ELIGIBLE CHARGES

* The member must meet the annual \$1,790 deductible before benefits are available.

** Foreign Country: Pays 80% after \$250 annual deductible up to a lifetime Max of \$50,000. Services must be rendered within 60 days of travel outside the U.S. Members with High Deductible Plan F must also meet the annual \$1790 deductible before benefits are available.

*** At Home Care: Pays up to \$40 per visit, \$1600 per year, 7 visits per week. One visit can equal up to 4 hours.