BlueCross BlueShield of Illinois

Underwritten by HCSC Insurance Services Company

Outline of Medicare Supplement Coverage — Standard Benefits for Plans A, F, F Plus, N, and N Plus; Standard and Medicare Select Benefits[4] for Plan G and Plan G Plus

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and High Deductible F.

Blue Cross and Blue Shield of Illinois does not offer those plans shaded in gray below.

Note: A ✔ means 100% of the benefit is paid

Benefits	**Plans Available to All Applicants**								**Medicare first eligible before 2020 only**	
	A	**B**	**D**	**G[1]**	**K[2]**	**L[2]**	**M**	**N**	**C**	**F[1]**
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	copays apply[3]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit in 2026[2]					$8,000[2]	$4,000[2]				

Blue Cross and Blue Shield of Illinois, which refers to HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2,950 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible. NOTE: HISC currently does not offer these high deductible options.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

[4] 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 $1,736 deductible is covered at any hospital from which you receive care. Only certain hospitals are network providers under this policy. Check with your physician to determine if he or she has admitting privileges at the network hospital. If he or she does not, you may be required to use another physician at time of hospitalization or you will be required to pay for all expenses. If you move out of the service area or out of state for this Medicare Select Plan, there will be a reduction of benefit coverage and you will have the opportunity to purchase any Medicare Supplement policy with comparable or lesser benefits offered by the insurer, or Medicare Supplement/ Select plans A, B, C, D, F, G, K, or L from any insurer within 63 days of termination. (Note: Plans C and F are no longer available to people new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy Plan C or Plan F. People new to Medicare on or after January 1, 2020, have the right to buy Plans D and G instead of Plans C and F.)

Monthly Premium Rates effective April 1, 2026

Rates shown are for Illinois residents living in the State South rating area. Specific ZIP codes for which these rates apply are listed in the appendix at the end of this document.

Age 65				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$180.53	$164.11	$207.52	$188.67
F	$246.88	$224.46	$283.80	$258.00
F Plus	$270.17	$247.75	$307.09	$281.29
G	$210.68	$191.54	$242.16	$220.17
G Plus	$233.97	$214.83	$265.45	$243.46
N	$154.43	$140.40	$177.50	$161.38
N Plus	$177.72	$163.69	$200.79	$184.67
G Select	$187.50	$170.47	$215.53	$195.95
G Select Plus	$210.79	$193.76	$238.82	$219.24

Age 66				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$180.53	$164.11	$207.52	$188.67
F	$246.88	$224.46	$283.80	$258.00
F Plus	$270.17	$247.75	$307.09	$281.29
G	$210.68	$191.54	$242.16	$220.17
G Plus	$233.97	$214.83	$265.45	$243.46
N	$154.43	$140.40	$177.50	$161.38
N Plus	$177.72	$163.69	$200.79	$184.67
G Select	$187.50	$170.47	$215.53	$195.95
G Select Plus	$210.79	$193.76	$238.82	$219.24

Age 67				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$180.53	$164.11	$207.52	$188.67
F	$246.88	$224.46	$283.80	$258.00
F Plus	$270.17	$247.75	$307.09	$281.29
G	$210.68	$191.54	$242.16	$220.17
G Plus	$233.97	$214.83	$265.45	$243.46
N	$154.43	$140.40	$177.50	$161.38
N Plus	$177.72	$163.69	$200.79	$184.67
G Select	$187.50	$170.47	$215.53	$195.95
G Select Plus	$210.79	$193.76	$238.82	$219.24

Age 68				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$190.10	$172.84	$218.50	$198.64
F	$256.72	$233.42	$295.09	$268.26
F Plus	$280.01	$256.71	$318.38	$291.55
G	$221.60	$201.45	$254.70	$231.54
G Plus	$244.89	$224.74	$277.99	$254.83
N	$162.76	$147.97	$187.08	$170.09
N Plus	$186.05	$171.26	$210.37	$193.38
G Select	$197.22	$179.28	$226.68	$206.08
G Select Plus	$220.51	$202.57	$249.97	$229.37

Age 69				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$200.72	$182.47	$230.72	$209.76
F	$268.76	$244.32	$308.92	$280.84
F Plus	$292.05	$267.61	$332.21	$304.13
G	$233.68	$212.45	$268.65	$244.22
G Plus	$256.97	$235.74	$291.94	$267.51
N	$172.26	$156.61	$198.02	$180.01
N Plus	$195.55	$179.90	$221.31	$203.30
G Select	$207.97	$189.07	$239.10	$217.36
G Select Plus	$231.26	$212.36	$262.39	$240.65

Age 70				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$211.34	$192.15	$242.92	$220.84
F	$281.85	$256.24	$323.97	$294.53
F Plus	$305.14	$279.53	$347.26	$317.82
G	$247.01	$224.58	$283.93	$258.12
G Plus	$270.30	$247.87	$307.22	$281.41
N	$181.75	$165.26	$208.92	$189.93
N Plus	$205.04	$188.55	$232.21	$213.22
G Select	$219.84	$199.88	$252.69	$229.72
G Select Plus	$243.13	$223.17	$275.98	$253.01

Age 71				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$221.95	$201.77	$255.11	$231.93
F	$296.05	$269.15	$340.29	$309.37
F Plus	$319.34	$292.44	$363.58	$332.66
G	$260.35	$236.68	$299.25	$272.04
G Plus	$283.64	$259.97	$322.54	$295.33
N	$191.27	$173.86	$219.86	$199.88
N Plus	$214.56	$197.15	$243.15	$223.17
G Select	$231.71	$210.64	$266.33	$242.11
G Select Plus	$255.00	$233.93	$289.62	$265.40

Age 72				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$231.53	$210.47	$266.12	$241.93
F	$310.27	$282.07	$356.63	$324.22
F Plus	$333.56	$305.36	$379.92	$347.51
G	$273.69	$248.79	$314.57	$285.96
G Plus	$296.98	$272.08	$337.86	$309.25
N	$200.75	$182.51	$230.76	$209.81
N Plus	$224.04	$205.80	$254.05	$233.10
G Select	$243.58	$221.43	$279.97	$254.50
G Select Plus	$266.87	$244.72	$303.26	$277.79

Age 73				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$241.06	$219.17	$277.08	$251.91
F	$323.38	$294.00	$371.68	$337.92
F Plus	$346.67	$317.29	$394.97	$361.21
G	$285.77	$259.79	$328.45	$298.61
G Plus	$309.06	$283.08	$351.74	$321.90
N	$210.29	$191.17	$241.70	$219.73
N Plus	$233.58	$214.46	$264.99	$243.02
G Select	$254.33	$231.22	$292.32	$265.76
G Select Plus	$277.62	$254.51	$315.61	$289.05

Age 74				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$249.55	$226.89	$286.86	$260.79
F	$336.49	$305.90	$386.78	$351.61
F Plus	$359.78	$329.19	$410.07	$374.90
G	$297.86	$270.79	$342.39	$311.27
G Plus	$321.15	$294.08	$365.68	$334.56
N	$219.78	$199.81	$252.63	$229.67
N Plus	$243.07	$223.10	$275.92	$252.96
G Select	$265.10	$241.01	$304.73	$277.03
G Select Plus	$288.39	$264.30	$328.02	$300.32

Age 75				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$258.05	$234.61	$296.66	$269.67
F	$349.57	$317.81	$401.83	$365.31
F Plus	$372.86	$341.10	$425.12	$388.60
G	$309.96	$281.80	$356.30	$323.93
G Plus	$333.25	$305.09	$379.59	$347.22
N	$229.28	$208.46	$263.56	$239.60
N Plus	$252.57	$231.75	$286.85	$262.89
G Select	$275.86	$250.81	$317.11	$288.30
G Select Plus	$299.15	$274.10	$340.40	$311.59

Age 76				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$265.51	$241.38	$305.18	$277.43
F	$361.62	$328.74	$415.66	$377.87
F Plus	$384.91	$352.03	$438.95	$401.16
G	$322.10	$292.81	$370.23	$336.58
G Plus	$345.39	$316.10	$393.52	$359.87
N	$237.61	$216.02	$273.09	$248.27
N Plus	$260.90	$239.31	$296.38	$271.56
G Select	$286.68	$260.60	$329.50	$299.56
G Select Plus	$309.97	$283.89	$352.79	$322.85

Age 77				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$272.91	$248.11	$313.70	$285.21
F	$373.62	$339.65	$429.47	$390.42
F Plus	$396.91	$362.94	$452.76	$413.71
G	$332.97	$302.72	$382.73	$347.96
G Plus	$356.26	$326.01	$406.02	$371.25
N	$245.92	$223.59	$282.66	$256.97
N Plus	$269.21	$246.88	$305.95	$280.26
G Select	$296.35	$269.43	$340.63	$309.69
G Select Plus	$319.64	$292.72	$363.92	$332.98

Age 78				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$279.31	$253.93	$321.05	$291.85
F	$384.55	$349.60	$442.01	$401.83
F Plus	$407.84	$372.89	$465.30	$425.12
G	$343.90	$312.62	$395.29	$359.37
G Plus	$367.19	$335.91	$418.58	$382.66
N	$254.24	$231.11	$292.21	$265.66
N Plus	$277.53	$254.40	$315.50	$288.95
G Select	$306.07	$278.24	$351.81	$319.84
G Select Plus	$329.36	$301.53	$375.10	$343.13

Age 79				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$284.62	$258.75	$327.13	$297.40
F	$395.47	$359.52	$454.60	$413.27
F Plus	$418.76	$382.81	$477.89	$436.56
G	$353.59	$321.45	$406.42	$369.47
G Plus	$376.88	$344.74	$429.71	$392.76
N	$262.55	$238.68	$301.80	$274.37
N Plus	$285.84	$261.97	$325.09	$297.66
G Select	$314.69	$286.09	$361.71	$328.84
G Select Plus	$337.98	$309.38	$385.00	$352.13

Age 80				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$292.46	$265.89	$336.17	$305.62
F	$405.87	$368.98	$466.52	$424.13
F Plus	$429.16	$392.27	$489.81	$447.42
G	$363.38	$330.34	$417.69	$379.74
G Plus	$386.67	$353.63	$440.98	$403.03
N	$269.85	$245.32	$310.15	$281.97
N Plus	$293.14	$268.61	$333.44	$305.26
G Select	$323.40	$294.01	$371.75	$337.97
G Select Plus	$346.69	$317.30	$395.04	$361.26

Age 81				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$300.17	$272.88	$345.01	$313.66
F	$416.03	$378.20	$478.21	$434.73
F Plus	$439.32	$401.49	$501.50	$458.02
G	$373.00	$339.08	$428.74	$389.77
G Plus	$396.29	$362.37	$452.03	$413.06
N	$276.97	$251.80	$318.37	$289.43
N Plus	$300.26	$275.09	$341.66	$312.72
G Select	$331.97	$301.78	$381.58	$346.89
G Select Plus	$355.26	$325.07	$404.87	$370.18

Age 82				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$307.67	$279.70	$353.64	$321.50
F	$425.93	$387.22	$489.57	$445.09
F Plus	$449.22	$410.51	$512.86	$468.38
G	$382.37	$347.59	$439.48	$399.53
G Plus	$405.66	$370.88	$462.77	$422.82
N	$283.91	$258.12	$326.37	$296.69
N Plus	$307.20	$281.41	$349.66	$319.98
G Select	$340.31	$309.36	$391.13	$355.58
G Select Plus	$363.60	$332.65	$414.42	$378.87

Age 83				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$315.00	$286.38	$362.06	$329.16
F	$435.55	$395.97	$500.64	$455.14
F Plus	$458.84	$419.26	$523.93	$478.43
G	$391.47	$355.89	$449.98	$409.08
G Plus	$414.76	$379.18	$473.27	$432.37
N	$290.69	$264.29	$334.14	$303.77
N Plus	$313.98	$287.58	$357.43	$327.06
G Select	$348.41	$316.75	$400.48	$364.09
G Select Plus	$371.70	$340.04	$423.77	$387.38

Age 84				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$322.17	$292.86	$370.29	$336.61
F	$444.95	$404.51	$511.47	$464.97
F Plus	$468.24	$427.80	$534.76	$488.26
G	$400.35	$363.96	$460.17	$418.35
G Plus	$423.64	$387.25	$483.46	$441.64
N	$297.28	$270.27	$341.74	$310.69
N Plus	$320.57	$293.56	$365.03	$333.98
G Select	$356.30	$323.92	$409.55	$372.33
G Select Plus	$379.59	$347.21	$432.84	$395.62

Age 85				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$329.08	$299.17	$378.27	$343.89
F	$454.13	$412.84	$521.98	$474.54
F Plus	$477.42	$436.13	$545.27	$497.83
G	$409.02	$371.83	$470.13	$427.40
G Plus	$432.31	$395.12	$493.42	$450.69
N	$303.75	$276.13	$349.12	$317.40
N Plus	$327.04	$299.42	$372.41	$340.69
G Select	$364.03	$330.93	$418.42	$380.39
G Select Plus	$387.32	$354.22	$441.71	$403.68

Age 86				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$335.86	$305.33	$386.05	$350.96
F	$463.03	$420.94	$532.21	$483.83
F Plus	$486.32	$444.23	$555.50	$507.12
G	$417.43	$379.48	$479.80	$436.19
G Plus	$440.72	$402.77	$503.09	$459.48
N	$309.97	$281.81	$356.28	$323.90
N Plus	$333.26	$305.10	$379.57	$347.19
G Select	$371.51	$337.74	$427.02	$388.21
G Select Plus	$394.80	$361.03	$450.31	$411.50

Age 87				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$342.43	$311.30	$393.60	$357.83
F	$471.71	$428.82	$542.17	$492.88
F Plus	$495.00	$452.11	$565.46	$516.17
G	$425.65	$386.95	$489.22	$444.76
G Plus	$448.94	$410.24	$512.51	$468.05
N	$316.07	$287.34	$363.30	$330.27
N Plus	$339.36	$310.63	$386.59	$353.56
G Select	$378.82	$344.38	$435.40	$395.84
G Select Plus	$402.11	$367.67	$458.69	$419.13

Age 88				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$348.84	$317.14	$400.99	$364.53
F	$480.09	$436.45	$551.82	$501.66
F Plus	$503.38	$459.74	$575.11	$524.95
G	$433.58	$394.17	$498.36	$453.08
G Plus	$456.87	$417.46	$521.65	$476.37
N	$321.97	$292.72	$370.07	$336.44
N Plus	$345.26	$316.01	$393.36	$359.73
G Select	$385.88	$350.82	$443.53	$403.23
G Select Plus	$409.17	$374.11	$466.82	$426.52

Age 89				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$355.08	$322.80	$408.15	$371.05
F	$488.25	$443.89	$561.24	$510.24
F Plus	$511.54	$467.18	$584.53	$533.53
G	$441.30	$401.18	$507.22	$461.10
G Plus	$464.59	$424.47	$530.51	$484.39
N	$327.70	$297.90	$376.66	$342.43
N Plus	$350.99	$321.19	$399.95	$365.72
G Select	$392.76	$357.05	$451.43	$410.37
G Select Plus	$416.05	$380.34	$474.72	$433.66

Age 90				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$361.11	$328.29	$415.05	$377.33
F	$496.18	$451.10	$570.32	$518.48
F Plus	$519.47	$474.39	$593.61	$541.77
G	$448.80	$408.01	$515.85	$468.98
G Plus	$472.09	$431.30	$539.14	$492.27
N	$333.26	$302.97	$383.06	$348.23
N Plus	$356.55	$326.26	$406.35	$371.52
G Select	$399.43	$363.13	$459.11	$417.39
G Select Plus	$422.72	$386.42	$482.40	$440.68

Age 91				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$366.95	$333.62	$421.79	$383.45
F	$503.87	$458.07	$579.14	$526.50
F Plus	$527.16	$481.36	$602.43	$549.79
G	$456.04	$414.60	$524.17	$476.53
G Plus	$479.33	$437.89	$547.46	$499.82
N	$338.65	$307.85	$389.25	$353.87
N Plus	$361.94	$331.14	$412.54	$377.16
G Select	$405.87	$368.99	$466.52	$424.11
G Select Plus	$429.16	$392.28	$489.81	$447.40

Age 92				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$372.63	$338.75	$428.31	$389.38
F	$511.26	$464.80	$587.68	$534.26
F Plus	$534.55	$488.09	$610.97	$557.55
G	$463.03	$420.94	$532.23	$483.86
G Plus	$486.32	$444.23	$555.52	$507.15
N	$343.85	$312.59	$395.24	$359.32
N Plus	$367.14	$335.88	$418.53	$382.61
G Select	$412.10	$374.63	$473.68	$430.64
G Select Plus	$435.39	$397.92	$496.97	$453.93

Age 93				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$378.11	$343.75	$434.62	$395.11
F	$518.45	$471.33	$595.89	$541.74
F Plus	$541.74	$494.62	$619.18	$565.03
G	$469.82	$427.12	$540.03	$490.96
G Plus	$493.11	$450.41	$563.32	$514.25
N	$348.88	$317.17	$401.02	$364.57
N Plus	$372.17	$340.46	$424.31	$387.86
G Select	$418.15	$380.13	$480.62	$436.96
G Select Plus	$441.44	$403.42	$503.91	$460.25

Age 94				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$383.40	$348.57	$440.67	$400.63
F	$525.37	$477.61	$603.86	$548.98
F Plus	$548.66	$500.90	$627.15	$572.27
G	$476.39	$433.07	$547.56	$497.80
G Plus	$499.68	$456.36	$570.85	$521.09
N	$353.74	$321.59	$406.64	$369.68
N Plus	$377.03	$344.88	$429.93	$392.97
G Select	$423.98	$385.44	$487.33	$443.04
G Select Plus	$447.27	$408.73	$510.62	$466.33

Age 95				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$388.54	$353.22	$446.62	$406.00
F	$532.05	$483.69	$611.55	$555.97
F Plus	$555.34	$506.98	$634.84	$579.26
G	$482.69	$438.82	$554.83	$504.37
G Plus	$505.98	$462.11	$578.12	$527.66
N	$358.42	$325.85	$412.01	$374.54
N Plus	$381.71	$349.14	$435.30	$397.83
G Select	$429.60	$390.55	$493.79	$448.89
G Select Plus	$452.89	$413.84	$517.08	$472.18

Age 96				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$393.47	$357.72	$452.30	$411.18
F	$538.46	$489.52	$618.90	$562.67
F Plus	$561.75	$512.81	$642.19	$585.96
G	$488.77	$444.35	$561.80	$510.73
G Plus	$512.06	$467.64	$585.09	$534.02
N	$362.95	$329.95	$417.21	$379.30
N Plus	$386.24	$353.24	$440.50	$402.59
G Select	$435.01	$395.47	$499.99	$454.55
G Select Plus	$458.30	$418.76	$523.28	$477.84

Age 97				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$398.26	$362.05	$457.76	$416.16
F	$544.67	$495.14	$626.05	$569.15
F Plus	$567.96	$518.43	$649.34	$592.44
G	$494.60	$449.64	$568.52	$516.84
G Plus	$517.89	$472.93	$591.81	$540.13
N	$367.29	$333.91	$422.18	$383.80
N Plus	$390.58	$357.20	$445.47	$407.09
G Select	$440.19	$400.18	$505.97	$459.99
G Select Plus	$463.48	$423.47	$529.26	$483.28

Age 98				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$402.82	$366.20	$463.02	$420.93
F	$550.58	$500.55	$632.85	$575.33
F Plus	$573.87	$523.84	$656.14	$598.62
G	$500.21	$454.75	$574.99	$522.70
G Plus	$523.50	$478.04	$598.28	$545.99
N	$371.45	$337.70	$426.97	$388.15
N Plus	$394.74	$360.99	$450.26	$411.44
G Select	$445.19	$404.73	$511.75	$465.21
G Select Plus	$468.48	$428.02	$535.04	$488.50

Age 99				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$407.19	$370.18	$468.03	$425.49
F	$556.30	$505.74	$639.42	$581.30
F Plus	$579.59	$529.03	$662.71	$604.59
G	$505.61	$459.65	$581.15	$528.33
G Plus	$528.90	$482.94	$604.44	$551.62
N	$375.47	$341.34	$431.57	$392.34
N Plus	$398.76	$364.63	$454.86	$415.63
G Select	$450.00	$409.10	$517.23	$470.21
G Select Plus	$473.29	$432.39	$540.52	$493.50

Age 100 +				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	$411.40	$374.00	$472.89	$429.91
F	$561.70	$510.67	$645.67	$586.99
F Plus	$584.99	$533.96	$668.96	$610.28
G	$510.76	$464.32	$587.08	$533.70
G Plus	$534.05	$487.61	$610.37	$556.99
N	$379.28	$344.79	$435.96	$396.33
N Plus	$402.57	$368.08	$459.25	$419 .62
G Select	$454.57	$413.24	$522.50	$474.99
G Select Plus	$477.86	$436.53	$545.79	$498.28

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, F, F Plus, N and N Plus. Those plans are available as Standard Plans only. 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 $1,736 deductible is covered at any hospital from which you receive care. Only certain hospitals are network providers under this policy. Check with your physician to determine if he or she has admitting privileges at the network hospital. If he or she does not, you may be required to use another physician at time of hospitalization or you will be required to pay for all expenses. If you move out of the service area or out of state for this Medicare Select Plan, there will be a reduction of benefit coverage and you will have the opportunity to purchase any Medicare Supplement policy with comparable or lesser benefits offered by the insurer, or Medicare Supplement/Select plans A, B, C, D, F, G, K, or L from any insurer within 63 days of termination. (Note: Plans C and F are no longer available to people new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy Plan C or Plan F. People new to Medicare on or after January 1, 2020, have the right to buy Plans D and G instead of Plans C and F.)

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.

Gender

One factor that will determine your premium is your gender. When completing the application, you will need to make a gender selection.

Tobacco User

A Tobacco User is a person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco) occurring on average of four or more times per week that last occurred within the past six months. Tobacco products include but are not limited to: cigarettes, cigars, smokeless tobacco products, electronic cigarettes, dissolvable tobacco products, and vaping.

If you meet the definition of a Tobacco User, you may pay a higher premium for your health coverage.

PREMIUM DISCOUNTS

A Blue Cross and Blue Shield of Illinois Medicare Supplement premium discount may be available. Eligibility criteria are described below. If you are eligible for a discount, the discount will be applied to your next bill and remain in effect as long as you are enrolled in your BCBSIL Medicare Supplement plan. Discounts cannot be combined; only one type of discount per member is permitted.

Household Discount

You may be eligible for a discount if you reside with a spouse or civil union/domestic partner or have resided with as many as three adults age 60 or older for the last 12 months. Applies to BCBSIL Medicare Supplement policies issued with an effective date on or after May 1, 2019. The discount is 10%.

Continue with Blue℠ Discount

You may be eligible for a discount if you enrolled in a BCBSIL Medicare Supplement policy issued with an effective date on or after April 1, 2022 and you were enrolled in a Blue Cross and Blue Shield commercial group or individual health insurance coverage plan and that coverage was within one year of your BCBSIL Medicare Supplement policy becoming effective. The discount is 7%.

Blue Family Discount℠

You may be eligible for a discount if you enrolled in a BCBSIL Medicare Supplement policy issued with an effective date on or after April 1, 2024 and you meet the criteria for both the Household Discount AND the Continue with Blue Discount. The discount is 12%.

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 Medicare Supplement**℠ **c/o Member Services, P.O. Box 3388 Scranton, PA 18505**. 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

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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, P.O. Box 3004, Naperville, IL 60566-9747 or fax (888) 235-2949.**

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 F, G, G Plus, K, L and N are Medicare Select policies currently available if you live within 30 miles of a Medicare Select hospital. Part A benefits may be restricted if you receive services in a hospital that is not a Medicare Select Hospital. NOTE: HISC only offers the Medicare Select option on Plans G and G Plus.

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

Services	Medicare Pays	Plan A Pays	You Pay
Hospitalization[5] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,736	$0	$1,736 (Part A deductible)
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $868 a day	$868 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[6]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[5] 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 $217 a day	$0	Up to $217 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

[5] 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.

[6] 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			
Services	**Medicare Pays**	**Plan A 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 $283 of Medicare-approved amounts[7]	$0	$0	$283 (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 $283 of Medicare-approved amounts[7]	$0	$0	$283 (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 A Pays**	**You Pay**
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $283 of Medicare-approved amounts[7]	$0	$0	$283 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0

[7] Once you have been billed $283 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Plan F

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

Services	Medicare Pays	Plan F Pays	You Pay
Hospitalization[5] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $868 a day	$868 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[6]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[5] 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 $217 a day	Up to $217 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

Plan F

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan F 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 $283 of Medicare-approved amounts[7]	$0	$283 (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 $283 of Medicare-approved amounts[7]	$0	$283 (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 Pays**	**You Pay**
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $283 of Medicare-approved amounts[7]	$0	$283 (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 Plus

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

Services	Medicare Pays	Plan F Plus Pays	You Pay
Hospitalization[5] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $868 a day	$868 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[6]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[5] 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 $217 a day	Up to $217 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

Plan F Plus

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan F Plus 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 $283 of Medicare-approved amounts[7]	$0	$283 (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 $283 of Medicare-approved amounts[7]	$0	$283 (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 Plus Pays**	**You Pay**
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $283 of Medicare-approved amounts[7]	$0	$283 (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 Plus

INNOVATIVE BENEFITS			
DENTAL			
Services	**Medicare Pays**	**Plan F Plus Pays**	**You Pay**
Diagnostic Evaluations			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Preventive Services			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Diagnostic Radiographs			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Basic Restorative Services[8]	$0	50%	50%
Non-Surgical Extractions			
In Network	$0	75%	25%
Out of Network	$0	50%	50%
VISION			
Services	**Medicare Pays**	**Plan F Plus Pays**	**You Pay**
Annual Routine Examination			
In Network	$0	100%	$0
Out of Network	$0	All except $40	$40
Materials Allowance			
In Network	$0	$130	Remaining Balance
Out of Network	$0	$65	Remaining Balance
HEARING[9]			
Services	**Medicare Pays**	**Plan F Plus Pays**	**You Pay**
Annual Routine Examination	$0	100%	$0
Hardware Discounts	$0	Generally 30%	Remaining Balance

[8] Once per tooth per calendar year.

[9] All services must be received in network.

Plan G

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

Services	Medicare Pays	Plan G Pays	You Pay
Hospitalization[5] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $868 a day	$868 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[6]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[5] 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 $217 a day	Up to $217 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

Plan G

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan G 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 $283 of Medicare-approved amounts[7]	$0	$0	$283 (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 $283 of Medicare-approved amounts[7]	$0	$0	$283 (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 G Pays**	**You Pay**
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $283 of Medicare-approved amounts[7]	$0	$0	$283 (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 G Plus

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Hospitalization[5] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $868 a day	$868 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[6]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[5] 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 $217 a day	Up to $217 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

Plan G Plus

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan G Plus 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 $283 of Medicare-approved amounts[7]	$0	$0	$283 (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 $283 of Medicare-approved amounts[7]	$0	$0	$283 (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 G Plus Pays**	**You Pay**
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $283 of Medicare-approved amounts[7]	$0	$0	$283 (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 G Plus

INNOVATIVE BENEFITS			
DENTAL			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Diagnostic Evaluations			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Preventive Services			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Diagnostic Radiographs			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Basic Restorative Services[8]	$0	50%	50%
Non-Surgical Extractions			
In Network	$0	75%	25%
Out of Network	$0	50%	50%
VISION			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Annual Routine Examination			
In Network	$0	100%	$0
Out of Network	$0	All except $40	$40
Materials Allowance			
In Network	$0	$130	Remaining Balance
Out of Network	$0	$65	Remaining Balance
HEARING[9]			
Services	**Medicare Pays**	**Plan G Plus Pays**	**You Pay**
Annual Routine Examination	$0	100%	$0
Hardware Discounts	$0	Generally 30%	Remaining Balance

Plan N

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD			
Services	**Medicare Pays**	**Plan N Pays**	**You Pay**
Hospitalization[5] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $868 a day	$868 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[6]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[5] 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 $217 a day	Up to $217 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

Plan N

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan N 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 $283 of Medicare-approved amounts[7]	$0	$0	$283 (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 $283 of Medicare-approved amounts[7]	$0	$0	$283 (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 N Pays**	**You Pay**
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $283 of Medicare-approved amounts[7]	$0	$0	$283 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0

Plan N

OTHER BENEFITS – NOT COVERED BY MEDICARE			
Services	**Medicare Pays**	**Plan N Pays**	**You Pay**
Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan N Plus

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

Services	Medicare Pays	Plan N Plus Pays	You Pay
Hospitalization[5] Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A deductible)	$0
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but $868 a day	$868 a day	$0
– Additional 365 days once Lifetime Reserve days are used	$0	100% of Medicare-eligible expenses	$0[6]
Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care[5] 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 $217 a day	Up to $217 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

Plan N Plus

MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR			
Services	**Medicare Pays**	**Plan N Plus 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 $283 of Medicare-approved amounts[7]	$0	$0	$283 (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 $283 of Medicare-approved amounts[7]	$0	$0	$283 (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 N Plus Pays**	**You Pay**
Home Health Care Medicare-approved Services			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
– First $283 of Medicare-approved amounts[7]	$0	$0	$283 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	$0

Plan N Plus

OTHER BENEFITS – NOT COVERED BY MEDICARE			
Services	**Medicare Pays**	**Plan N Plus Pays**	**You Pay**
Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Plan N Plus

INNOVATIVE BENEFITS			
DENTAL			
Services	**Medicare Pays**	**Plan N Plus Pays**	**You Pay**
Diagnostic Evaluations			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Preventive Services			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Diagnostic Radiographs			
In Network	$0	100%	$0
Out of Network	$0	50%	50%
Basic Restorative Services[8]	$0	50%	50%
Non-Surgical Extractions			
In Network	$0	75%	25%
Out of Network	$0	50%	50%
VISION			
Services	**Medicare Pays**	**Plan N Plus Pays**	**You Pay**
Annual Routine Examination			
In Network	$0	100%	$0
Out of Network	$0	All except $40	$40
Materials Allowance			
In Network	$0	$130	Remaining Balance
Out of Network	$0	$65	Remaining Balance
HEARING[9]			
Services	**Medicare Pays**	**Plan N Plus Pays**	**You Pay**
Annual Routine Examination	$0	100%	$0
Hardware Discounts	$0	Generally 30%	Remaining Balance

Appendix: ZIP Codes for the State South Rating Area (Rating Area 3)

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Important Information about Quotes for Medicare Supplement
Quoted prices are based on the criteria specified during your search. This illustration is subject to Blue Cross and Blue Shield of Illinois's rating or underwriting and approval, as appropriate, and does not guarantee rates, coverage or effective date. Furthermore, rates are subject to change if any of the information you have provided changes when and if a policy is approved. In addition, Blue Cross and Blue Shield of Illinois reserves the right to change rates from time to time. Not connected with or endorsed by the U.S. Government or Federal Medicare Program.

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