



This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" 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.

BASIC BENEFITS:

- Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses – Part B coinsurance (generally 20% of Medicare-approved expenses), or copayments for hospital outpatient services. Plans K², L² and N require insureds to pay a portion of Part B coinsurance or copayments.
- Blood – First 3 pints of blood each year.
- Hospice – Part A coinsurance.

A	Basic Benefits, including 100% Part B Coinsurance						
B	Basic Benefits, including 100% Part B Coinsurance		Part A Deductible				
D	Basic Benefits, including 100% Part B Coinsurance	Skilled Nursing Facility Coinsurance	Part A Deductible			Foreign Travel Emergency	
G G¹	Basic Benefits, including 100% Part B Coinsurance	Skilled Nursing Facility Coinsurance	Part A Deductible		Part B Excess (100%)	Foreign Travel Emergency	
K²	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	50% Skilled Nursing Facility Coinsurance	50% Part A Deductible				Out-of-pocket limit ³ \$7,060; paid at 100% after limit reached
L²	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	75% Skilled Nursing Facility Coinsurance	75% Part A Deductible				Out-of-pocket limit ³ \$3,530; paid at 100% after limit reached
M	Basic Benefits, including 100% Part B Coinsurance	Skilled Nursing Facility Coinsurance	50% Part A Deductible			Foreign Travel Emergency	
N	Basic Benefits, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER	Skilled Nursing Facility Coinsurance	Part A Deductible			Foreign Travel Emergency	
Only available if Medicare-eligible before 2020							
C	Basic Benefits, including 100% Part B Coinsurance	Skilled Nursing Facility Coinsurance	Part A Deductible	Part B Deductible		Foreign Travel Emergency	
F F¹	Basic Benefits, including 100% Part B Coinsurance ¹	Skilled Nursing Facility Coinsurance	Part A Deductible	Part B Deductible	Part B Excess (100%)	Foreign Travel Emergency	

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 These high deductible plans pay the same benefits as Plans F and G after one has paid a calendar-year \$2,800 deductible. Benefits from High Deductible Plans F and G will not begin until out-of-pocket expenses are \$2,800. 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.
- ² Plans K and L provide for different cost-sharing for items and services than the other plans we offer. Amounts that count towards the annual limit are noted with an asterisk (*). Once you reach the annual limit, the plan pays 100% of the Medicare copayments and coinsurance 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.
- ³ The out-of-pocket annual limit will increase each year for inflation.

Monthly Premium Rates effective April 1, 2023

Rates shown are for Illinois residents living in Cook, DuPage, Kane, Lake, McHenry or Will Counties only.

If you're an Illinois resident living outside of Cook, DuPage, Kane, Lake, McHenry or Will County, please call the toll-free number that appears on the application and throughout the information packet.

Age 65				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$122.12	\$111.02	\$140.37	\$127.62
F	\$167.00	\$151.83	\$191.97	\$174.52
G	\$140.72	\$127.93	\$161.74	\$147.04
G Plus	\$163.14	\$150.35	\$184.16	\$169.46
N	\$119.74	\$108.86	\$137.64	\$125.13

Age 66				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$122.12	\$111.02	\$140.37	\$127.62
F	\$167.00	\$151.83	\$191.97	\$174.52
G	\$140.72	\$127.93	\$161.74	\$147.04
G Plus	\$163.14	\$150.35	\$184.16	\$169.46
N	\$119.74	\$108.86	\$137.64	\$125.13

Age 67				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$122.12	\$111.02	\$140.37	\$127.62
F	\$167.00	\$151.83	\$191.97	\$174.52
G	\$140.72	\$127.93	\$161.74	\$147.04
G Plus	\$163.14	\$150.35	\$184.16	\$169.46
N	\$119.74	\$108.86	\$137.64	\$125.13

Age 68				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$128.59	\$116.90	\$147.79	\$134.37
F	\$173.66	\$157.88	\$199.61	\$181.46
G	\$147.99	\$134.54	\$170.11	\$154.64
G Plus	\$170.41	\$156.96	\$192.53	\$177.06
N	\$126.18	\$114.72	\$145.05	\$131.87

Age 69				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$135.78	\$123.44	\$156.06	\$141.88
F	\$181.79	\$165.27	\$208.95	\$189.96
G	\$156.08	\$141.89	\$179.41	\$163.10
G Plus	\$178.50	\$164.31	\$201.83	\$185.52
N	\$133.55	\$121.42	\$153.52	\$139.57

Age 70				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$142.96	\$129.97	\$164.32	\$149.38
F	\$190.65	\$173.32	\$219.15	\$199.23
G	\$164.97	\$149.98	\$189.63	\$172.39
G Plus	\$187.39	\$172.40	\$212.05	\$194.81
N	\$140.93	\$128.12	\$161.99	\$147.26

Age 71				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$150.14	\$136.49	\$172.57	\$156.89
F	\$200.26	\$182.06	\$230.18	\$209.26
G	\$173.87	\$158.07	\$199.85	\$181.68
G Plus	\$196.29	\$180.49	\$222.27	\$204.10
N	\$148.30	\$134.82	\$170.45	\$154.96

Age 72				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$156.60	\$142.37	\$180.01	\$163.65
F	\$209.87	\$190.80	\$241.23	\$219.30
G	\$182.77	\$166.16	\$210.08	\$190.98
G Plus	\$205.19	\$188.58	\$232.50	\$213.40
N	\$155.66	\$141.51	\$178.92	\$162.66

Age 73				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$163.06	\$148.24	\$187.43	\$170.40
F	\$218.73	\$198.85	\$251.43	\$228.57
G	\$190.85	\$173.50	\$219.37	\$199.43
G Plus	\$213.27	\$195.92	\$241.79	\$221.85
N	\$163.04	\$148.22	\$187.40	\$170.37

Age 74				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$168.81	\$153.47	\$194.05	\$176.41
F	\$227.61	\$206.92	\$261.61	\$237.83
G	\$198.94	\$180.86	\$228.67	\$207.89
G Plus	\$221.36	\$203.28	\$251.09	\$230.31
N	\$170.41	\$154.92	\$195.87	\$178.07

Age 75				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$174.56	\$158.69	\$200.65	\$182.42
F	\$236.47	\$214.98	\$271.80	\$247.10
G	\$207.03	\$188.21	\$237.96	\$216.33
G Plus	\$229.45	\$210.63	\$260.38	\$238.75
N	\$177.78	\$161.62	\$204.34	\$185.77

Age 76				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$179.59	\$163.27	\$206.42	\$187.66
F	\$244.59	\$222.37	\$281.15	\$255.60
G	\$215.12	\$195.56	\$247.26	\$224.79
G Plus	\$237.54	\$217.98	\$269.68	\$247.21
N	\$184.22	\$167.48	\$211.75	\$192.50

Age 77				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$184.62	\$167.84	\$212.21	\$192.92
F	\$252.72	\$229.75	\$290.50	\$264.09
G	\$222.39	\$202.17	\$255.62	\$232.39
G Plus	\$244.81	\$224.59	\$278.04	\$254.81
N	\$190.67	\$173.34	\$219.16	\$199.24

Age 78				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$188.93	\$171.76	\$217.16	\$197.42
F	\$260.11	\$236.47	\$299.00	\$271.81
G	\$229.67	\$208.79	\$263.99	\$240.00
G Plus	\$252.09	\$231.21	\$286.41	\$262.42
N	\$197.11	\$179.20	\$226.58	\$205.98

Age 79				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$192.52	\$175.03	\$221.29	\$201.17
F	\$267.51	\$243.19	\$307.49	\$279.54
G	\$236.14	\$214.68	\$271.43	\$246.76
G Plus	\$258.56	\$237.10	\$293.85	\$269.18
N	\$203.56	\$185.06	\$233.99	\$212.72

Age 80				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$197.84	\$179.85	\$227.40	\$206.73
F	\$274.54	\$249.59	\$315.57	\$286.88
G	\$242.70	\$220.64	\$278.97	\$253.61
G Plus	\$265.12	\$243.06	\$301.39	\$276.03
N	\$209.23	\$190.21	\$240.49	\$218.62

Age 81				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$203.04	\$184.59	\$233.38	\$212.17
F	\$281.41	\$255.83	\$323.45	\$294.05
G	\$249.10	\$226.46	\$286.33	\$260.30
G Plus	\$271.52	\$248.88	\$308.75	\$282.72
N	\$214.75	\$195.23	\$246.84	\$224.40

Age 82				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$208.11	\$189.20	\$239.22	\$217.47
F	\$288.11	\$261.92	\$331.15	\$301.05
G	\$255.35	\$232.14	\$293.49	\$266.82
G Plus	\$277.77	\$254.56	\$315.91	\$289.24
N	\$220.14	\$200.13	\$253.04	\$230.04

Age 83				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$213.07	\$193.70	\$244.91	\$222.65
F	\$294.63	\$267.84	\$338.65	\$307.87
G	\$261.46	\$237.69	\$300.52	\$273.21
G Plus	\$283.88	\$260.11	\$322.94	\$295.63
N	\$225.39	\$204.90	\$259.06	\$235.51

Age 84				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$217.90	\$198.10	\$250.46	\$227.70
F	\$300.98	\$273.62	\$345.96	\$314.51
G	\$267.38	\$243.08	\$307.34	\$279.40
G Plus	\$289.80	\$265.50	\$329.76	\$301.82
N	\$230.51	\$209.55	\$264.96	\$240.87

Age 85				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$222.60	\$202.36	\$255.86	\$232.61
F	\$307.18	\$279.26	\$353.07	\$320.98
G	\$273.16	\$248.33	\$313.98	\$285.44
G Plus	\$295.58	\$270.75	\$336.40	\$307.86
N	\$235.49	\$214.09	\$270.68	\$246.08

Age 86				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$227.18	\$206.53	\$261.12	\$237.39
F	\$313.20	\$284.73	\$359.99	\$327.27
G	\$278.78	\$253.44	\$320.44	\$291.31
G Plus	\$301.20	\$275.86	\$342.86	\$313.73
N	\$240.33	\$218.49	\$276.25	\$251.13

Age 87				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$231.63	\$210.58	\$266.25	\$242.04
F	\$319.06	\$290.06	\$366.73	\$333.40
G	\$284.25	\$258.42	\$326.74	\$297.03
G Plus	\$306.67	\$280.84	\$349.16	\$319.45
N	\$245.05	\$222.78	\$281.67	\$256.07

Age 88				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$235.96	\$214.52	\$271.23	\$246.58
F	\$324.74	\$295.22	\$373.26	\$339.33
G	\$289.56	\$263.24	\$332.84	\$302.58
G Plus	\$311.98	\$285.66	\$355.26	\$325.00
N	\$249.63	\$226.94	\$286.94	\$260.85

Age 89				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$240.18	\$218.35	\$276.07	\$250.98
F	\$330.27	\$300.25	\$379.63	\$345.12
G	\$294.71	\$267.92	\$338.75	\$307.96
G Plus	\$317.13	\$290.34	\$361.17	\$330.38
N	\$254.07	\$230.98	\$292.04	\$265.49

Age 90				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$244.25	\$222.05	\$280.75	\$255.23
F	\$335.62	\$305.12	\$385.78	\$350.71
G	\$299.73	\$272.48	\$344.52	\$313.20
G Plus	\$322.15	\$294.90	\$366.94	\$335.62
N	\$258.38	\$234.90	\$296.99	\$270.00

Age 91				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$248.22	\$225.66	\$285.31	\$259.37
F	\$340.81	\$309.83	\$391.73	\$356.13
G	\$304.56	\$276.88	\$350.07	\$318.25
G Plus	\$326.98	\$299.30	\$372.49	\$340.67
N	\$262.57	\$238.70	\$301.80	\$274.36

Age 92				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$252.04	\$229.14	\$289.72	\$263.38
F	\$345.83	\$314.40	\$397.52	\$361.38
G	\$309.24	\$281.13	\$355.46	\$323.15
G Plus	\$331.66	\$303.55	\$377.88	\$345.57
N	\$266.60	\$242.37	\$306.43	\$278.58

Age 93				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$255.77	\$232.52	\$293.98	\$267.26
F	\$350.68	\$318.81	\$403.08	\$366.44
G	\$313.77	\$285.25	\$360.66	\$327.88
G Plus	\$336.19	\$307.67	\$383.08	\$350.30
N	\$270.51	\$245.92	\$310.92	\$282.66

Age 94				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$259.35	\$235.77	\$298.10	\$271.00
F	\$355.36	\$323.06	\$408.46	\$371.33
G	\$318.15	\$289.23	\$365.69	\$332.45
G Plus	\$340.57	\$311.65	\$388.11	\$354.87
N	\$274.28	\$249.35	\$315.27	\$286.61

Age 95				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$262.82	\$238.93	\$302.09	\$274.63
F	\$359.88	\$327.17	\$413.66	\$376.06
G	\$322.37	\$293.07	\$370.54	\$336.86
G Plus	\$344.79	\$315.49	\$392.96	\$359.28
N	\$277.90	\$252.64	\$319.43	\$290.40

Age 96				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$266.16	\$241.97	\$305.93	\$278.13
F	\$364.22	\$331.12	\$418.66	\$380.60
G	\$326.43	\$296.76	\$375.21	\$341.10
G Plus	\$348.85	\$319.18	\$397.63	\$363.52
N	\$281.41	\$255.83	\$323.47	\$294.06

Age 97				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$269.38	\$244.90	\$309.63	\$281.49
F	\$368.43	\$334.93	\$423.48	\$384.98
G	\$330.33	\$300.30	\$379.70	\$345.18
G Plus	\$352.75	\$322.72	\$402.12	\$367.60
N	\$284.77	\$258.89	\$327.33	\$297.57

Age 98				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$272.47	\$247.71	\$313.19	\$284.72
F	\$372.42	\$338.57	\$428.08	\$389.17
G	\$334.07	\$303.71	\$384.00	\$349.10
G Plus	\$356.49	\$326.13	\$406.42	\$371.52
N	\$288.00	\$261.82	\$331.04	\$300.95

Age 99				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$275.44	\$250.40	\$316.59	\$287.81
F	\$376.28	\$342.08	\$432.50	\$393.19
G	\$337.67	\$306.98	\$388.13	\$352.85
G Plus	\$360.09	\$329.40	\$410.55	\$375.27
N	\$291.11	\$264.65	\$334.60	\$304.19

Age 100 +				
	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$278.27	\$252.98	\$319.86	\$290.79
F	\$379.95	\$345.41	\$436.74	\$397.04
G	\$341.11	\$310.10	\$392.08	\$356.44
G Plus	\$363.53	\$332.52	\$414.50	\$378.86
N	\$294.06	\$267.33	\$338.01	\$307.28

You have the option to purchase any of the Medicare Supplement benefit plans shown on the front cover in white as Standard Plans.

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 Blue Cross and Blue Shield of Illinois Medicare Supplement plan. Discounts cannot be combined; only one type of discount per member 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 Blue Cross and Blue Shield of Illinois Medicare Supplement policies issued with an effective date on or after May 1, 2019.

Continue with BlueSM Discount

You may be eligible for a discount if you were enrolled in commercial group or individual coverage with a Blue Cross and Blue Shield Plan issued in Illinois, Montana, New Mexico, Oklahoma, or Texas and that coverage was within one year of your BCBSIL Medicare Supplement policy becoming effective. Applies to BCBSIL Medicare Supplement policies issued with an effective date on or after April 1, 2022.

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 SupplementSM 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.

Plan A

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

Services	Medicare Pays	Plan A Pays	You Pay
Hospitalization⁴ Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$0	\$1,632 (Part A deductible)
61st through 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$816 a day	\$816 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ⁵
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care⁴ 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 \$204 a day	\$0	Up to \$204 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

⁴ 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.

⁵ 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 \$240 of Medicare-approved amounts ⁶	\$0	\$0	\$240 (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 \$240 of Medicare-approved amounts ⁶	\$0	\$0	\$240 (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 \$240 of Medicare-approved amounts ⁶	\$0	\$0	\$240 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

⁶ Once you have been billed \$240 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
Hospitalization⁴ Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A deductible)	\$0
61st through 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$816 a day	\$816 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ⁵
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care⁴ 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 \$204 a day	Up to \$204 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 \$240 of Medicare-approved amounts ⁶	\$0	\$240 (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 \$240 of Medicare-approved amounts ⁶	\$0	\$240 (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 \$240 of Medicare-approved amounts ⁶	\$0	\$240 (Part B deductible)	\$0
– Remainder of Medicare-approved amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

Foreign Travel — Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Plan G

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

Services	Medicare Pays	Plan G Pays	You Pay
Hospitalization ⁴ Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A deductible)	\$0
61st through 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$816 a day	\$816 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ⁵
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care ⁴ 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 \$204 a day	Up to \$204 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 \$240 of Medicare-approved amounts ⁶	\$0	\$0	\$240 (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 \$240 of Medicare-approved amounts ⁶	\$0	\$0	\$240 (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 \$240 of Medicare-approved amounts ⁶	\$0	\$0	\$240 (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
Hospitalization³ Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A deductible)	\$0
61st through 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$816 a day	\$816 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ⁴
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care³ 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 \$204 a day	Up to \$204 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 \$240 of Medicare-approved amounts ⁵	\$0	\$0	\$240 (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 \$240 of Medicare-approved amounts ⁵	\$0	\$0	\$240 (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 \$240 of Medicare-approved amounts ⁵	\$0	\$0	\$240 (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 Services⁷	\$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

HEARING⁸

Services	Medicare Pays	Plan G Plus Pays	You Pay
Annual Routine Examination	\$0	100%	\$0
Hardware Discounts	\$0	Generally 30%	Remaining Balance

⁷ Once per tooth per calendar year.

⁸ All services must be received in network.

Plan N

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

Services	Medicare Pays	Plan N Pays	You Pay
Hospitalization ⁴ Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A deductible)	\$0
61st through 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$816 a day	\$816 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 ⁵
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care ⁴ 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 \$204 a day	Up to \$204 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 \$240 of Medicare-approved amounts ⁶	\$0	\$0	\$240 (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 \$240 of Medicare-approved amounts ⁶	\$0	\$0	\$240 (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 \$240 of Medicare-approved amounts ⁶	\$0	\$0	\$240 (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

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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