BLUE MEDICARE SUPPLEMENT℠

MEDICARE SELECT PLAN N

Your Health Care Benefit Policy

BlueCross BlueShield of Illinois

Medicare Supplement insurance plans are offered by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (hereinafter referred to as "Blue Cross and Blue Shield of Illinois" or "BCBSIL").

300 East Randolph, Chicago, Illinois 60601

CB-45.81 HCSC 01/23

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, A Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

YOUR RIGHT TO EXAMINE

You have the right to examine this Policy for a 30-day period after it has been issued. If for any reason you are not satisfied with the Medicare Supplement program described in this Policy, you may return this Policy to Blue Cross and Blue Shield of Illinois as long as you do so within 30 days of receipt and as long as you have not filed a claim. Blue Cross and Blue Shield of Illinois will refund any Medicare Supplement Premiums you paid.

GUARANTEED RENEWABILITY

This Policy cannot be cancelled or not renewed by Blue Cross and Blue Shield of Illinois for any reason other than non-payment of Medicare Supplement Premiums or material misrepresentation. However, Blue Cross and Blue Shield of Illinois may change the amount of Medicare Supplement Premiums due or automatically increase Medicare Supplement Premiums based upon the Policyholder's age classification.

Blue Cross and Blue Shield of Illinois, a
Division of Health Care Service Corporation,
A Mutual Legal Reserve Company, an
Independent Licensee of the Blue Cross
and Blue Shield Association

TABLE OF CONTENTS

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, A Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Department of Insurance addresses.
Can I assign my coverage?
Do you exchange medical information about me?
What about misstatements on my application?
What limits are there on legal action?
May I vote at the Annual Meeting?

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, A Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

A message to the Policyholder from

BLUE CROSS AND BLUE SHIELD OF ILLINOIS

Blue Cross and Blue Shield of Illinois agrees to pay certain Hospital, Skilled Nursing Facility, Physician and medical/surgical charges you incur provided you pay your Medicare Supplement Premiums for this coverage. This agreement is subject to all terms and conditions of this Policy.

THIS POLICY REPLACES ANY PREVIOUS POLICY OR CERTIFICATE YOU MAY HAVE BEEN ISSUED BY BLUE CROSS AND BLUE SHIELD OF ILLINOIS.

This Policy will explain your Medicare Supplement insurance. Be sure to read this Policy very carefully. It explains your rights and responsibilities and the rights and responsibilities of Blue Cross and Blue Shield of Illinois.

In this Policy, **you, your** and **yours** mean the Policyholder. That's the person insured by this Policy. **We, us,** and **our** mean Blue Cross and Blue Shield of Illinois.

This Policy, your application for coverage, and any endorsements or riders attached to this Policy make up your entire agreement with us.

Welcome to Blue Cross and Blue Shield of Illinois! We are happy to have you as a Member and pledge you our best service.

Sincerely,

Blue Cross and Blue Shield of Illinois

A Division of Health Care Service Corporation

A Mutual Legal Reserve Company

Stephen Harris, President Illinois Division

GLOSSARY

You, the Policyholder, are the only insured. You must be covered by Medicare. The definitions stated below will apply to the following terms when used in this Policy:

"**Accidental Injury**" means a bodily injury you receive as the direct result of an accident. An Accidental Injury cannot be the result of a disease or other bodily condition.

"**Assignment**" In the original Medicare plan, this means a doctor agrees to accept the Medicare-approved amount as full payment. If you are in the original Medicare plan, it can save you money if your doctor accepts Assignment. You still pay your share of the cost of the doctor's visit.

"**Calendar Year**" means the period commencing on January 1st and ending on the next succeeding December 31st, inclusive.

"**Calendar Year Deductible**" means the first dollar amount of your Part A and/or Part B charges incurred outside of the United States during a Calendar Year.

"**Coinsurance**" means the percentage of the Medicare approved amount that a Member pays after meeting the Medicare Deductible.

"**Effective Date**" (also referred to as "Coverage Date") means the date that the Member is enrolled on our membership records for coverage under this Policy.

"**Emergency Care**" means care given for a medical emergency when you believe that your health is in danger when every second counts.

"**Excess Charges**" If you are in the original Medicare plan, this is the difference between a doctor or other health care Provider actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

"**Explanation of Medicare Benefits Form**" means the Medicare notice of what medical services or supplies were covered, what charges were approved, how much was credited toward the Part A or B Deductible, and the amount that Medicare paid.

"**Foreign"** means any areas not included in the United States.

"**Grievance**" means a complaint about the way your Medicare health plan is giving care. For example, you may file a Grievance if you have a problem calling the plan or if you are unhappy with the way a staff person at the plan has behaved toward you. A Grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered.

"**Home Health Agency**" means an organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.

"**Home Health Care**" means limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, Hospital beds, oxygen, and walkers), medical supplies, and other services.

"**Hospice**" means a Medicare-certified program that provides care and support to terminally ill patients and their families.

“**Hospital**’’ means an institution primarily engaged in providing, by or under the supervision of a licensed Physician or a staff of licensed Physicians, inpatient diagnostic and therapeutic services or rehabilitation services, as further described in the Section of this Policy entitled “What Inpatient Hospital Services are Covered”.

“**Identification Card**” (ID Card) means the card BCBSIL issues identifying the Member as a BCBSIL Member. This card should be presented with your Medicare card whenever you receive health care services.

“**Inpatient Hospital Care**” means health care that you get when you are admitted to a Hospital.

“**Lifetime Reserve Days**” In original Medicare, these are additional days that Medicare will pay for when you're in a Hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each Lifetime Reserve Day, Medicare pays all covered costs except for a daily Coinsurance.

“**Medicaid**” means a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

“**Medically Necessary**” means health care services or supplies needed to diagnose or treat a Sickness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine as set forth in this Policy under section “What Do We Mean By Medically Necessary”.

“**Medicare**” means the federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

“**Medicare Benefit Period’’** means the way that original Medicare measures your use of Hospital and Skilled Nursing Facility (SNF) services. A benefit period begins the day you're admitted as an inpatient in a Hospital or SNF. The benefit period ends when you haven't gotten any Inpatient Hospital Care (or skilled care in a SNF) for 60 days in a row. If you go into a Hospital or a SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

“**Medicare Eligible Expense**’’ means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

“**Medicare Part A Benefits**” means Hospital insurance that pays for inpatient Hospital stays, care in a Skilled Nursing Facility, Hospice care, and some Home Health Care.

“**Medicare Part B Benefits**” means Medicare medical insurance that helps pay for doctor’s services, Outpatient Hospital care, durable medical equipment, and some medical services that are not covered by Part A.

“**Medicare Select**” means a type of Medicare Supplement (also referred to as Medigap) policy that may require you to use Hospitals and, in some cases, doctors within its network to be eligible for full benefits.

“**Medicare Supplement**” is also referred to as a Medigap policy. It is sold by private insurance companies to fill "gaps" in original Medicare plan coverage. Except in Minnesota, Massachusetts, and Wisconsin, there are 10 standardized policies labeled Plan A through Plan N. Medigap policies only work with the original Medicare plan.

“**Medicare Supplement Benefits**” means payments for health care services provided to a Member according to the terms of this Policy.

"**Medicare Supplement Premium**" means the periodic payment to an insurance company, or a health care plan for health or prescription drug coverage.

"**Member**" means the insured person who is eligible for coverage under this Policy.

"**Network Hospital**" means an eligible Hospital which has entered into a written agreement with the issuer to provided benefits covered under a Medicare Select policy.

"**Non-Network Hospital**" means an eligible Hospital which has not entered into a written agreement with the issuer to provided benefits covered under a Medicare Select policy.

"**Outpatient**" means medical or surgical care you get from a Hospital when your doctor hasn't written an order to admit to the Hospital as an inpatient. Outpatient Hospital care may include emergency department services, observation services, Outpatient surgery, lab tests, or X-rays. Your care may be considered Outpatient Hospital care even if you spend the night at the Hospital.

"**Physician**" means any types of professionals that are legally authorized by the state to practice medicine, regardless of whether they are Medicare, Medicaid, or Children's Health Insurance Program (CHIP) Providers.

"**Policyholder**" means the person to whom this Policy is issued.

"**Provider"** means a general term for a person, practitioner, institution, or facility that is licensed by the state or jurisdiction where the treatment is given and is recognized by Medicare.

"**Service Area**" means a geographic area where a health insurance plan accepts Members if it limits membership based on where people live, as defined in your outline of coverage.

"**Sickness**" means illness or disease of an insured person which first manifests itself after the Effective Date of insurance and while the insurance is in force.

"**Skilled Nursing Facility**" means a nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

"**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.

"**United States"** means all of the states, District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Norther Mariana Islands.

GENERAL INFORMATION ABOUT THIS POLICY

WHO IS COVERED BY THIS POLICY?

You, the Policyholder, are the only insured. You must be covered by Medicare Parts A and B. There is no family coverage.

WHEN DOES MY COVERAGE START AND END?

Coverage starts on your Effective Date (your ‘‘Coverage Date’’). However, inpatient benefits are covered only when your admission occurs on or after your Coverage Date. Your Coverage Date is shown on your ID Card. Your Medicare Supplement Premium must be paid before coverage can begin.

You may cancel at any time for any reason. Just send us written notice or call the number on the back of your ID Card. Your benefits will end on the date your Policy is cancelled.

We may cancel your Policy if:

- you don’t pay Medicare Supplement Premiums when due; or
- you make a material misrepresentation; or
- you are no longer eligible for Medicare Parts A and B.

We’ll send you written notice if your Policy is going to be cancelled.

NOTICE

Written notice to us must be sent to:

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

CAN YOU REINSTATE MY POLICY?

Yes. If we cancel your Policy because you don’t pay a Medicare Supplement Premium you may reapply. We will reinstate your Policy if the following conditions are met:

1. If we accept your application, and
2. We bill you, and
3. You pay, and we accept the billed Medicare Supplement Premium.

However, we’ll only cover treatment for:

- Accidental Injuries received after the date we accept payment; and
- Sicknesses beginning more than 10 days after we accept payment.

WHAT DOES THIS POLICY COVER?

This Policy provides Hospital service benefits and medical/surgical coverage. The Hospital benefits cover Hospital or Skilled Nursing Facility care.

Medical/surgical coverage includes Physician’s visits. It also covers most Outpatient services.

WHAT IF I BECOME ELIGIBLE FOR MEDICAID?

If you become eligible for benefits under Medicaid, you may request that we suspend your coverage. You may request that we suspend your coverage by giving us written notice or calling within 90 days after the date you become eligible for Medicaid.

When we ‘‘suspend coverage’’ this means that we will no longer provide benefits under this Policy and will refund any portion of your unused Medicare Supplement Premium to you. **We will not suspend your coverage for more than 24 months.**

We will reinstate your coverage when your eligibility for benefits under Medicaid ends. However, you must give us written notice within 90 days after the date you lose your Medicaid eligibility. When we reinstate you, your Medicare Supplement Premiums and benefits will be the same or similar to the Medicare Supplement Premiums and benefits you would have had if you had not suspended coverage under this Policy. You will not be subject to a pre-existing conditions waiting period.

HOW DOES THIS POLICY SUPPLEMENT MEDICARE?

This Medicare Supplement Plan N is a full supplement to Medicare as defined in the Illinois insurance code. This Policy does not pay your Medicare Part A Deductible. However, you will not have to pay your Medicare care Part A Deductible when Medicare-approved services are received in a Network Hospital. This Policy does not pay your Part B Deductible. It pays the difference between remaining charges approved for payment by Medicare and the amount Medicare actually pays up to the limiting charges established by law and shown on your Explanation of Medicare Benefit Form. This Policy will never duplicate Medicare benefits.

MEDICARE MUST APPROVE SERVICE

We only pay for services which have been approved by Medicare. If a charge exceeds the Medicare Eligible Expense, we won’t pay the excess. The ‘‘**Medicare Eligible Expense**’’ is the amount which Medicare has decided is appropriate in your community for the service you received.

TERMINATION OF THIS POLICY DUE TO A CHANGE IN LAW

Medicare Supplement policies of this type are governed by a federal program. If that program is substantially modified or becomes invalid because of a change in law, the Secretary of Health and Human Services may require that all policies issued under the program be discontinued. In this event, your Policy will terminate. We’ll notify you in writing of the termination.

You may then apply to continue coverage under any other Medicare supplement policy we offer which does not include the Medicare Select program, but provides **comparable or lesser benefits**. You will not have to provide us proof that your health is acceptable for insurance.

A Medicare Supplement policy is considered to have comparable or lesser benefits unless it provides coverage for one or more of the following benefits **not** included in this Policy:

- the Medicare Part A Deductible;
- prescription drugs;
- at-home recovery services; or
- Part B Excess Charges.

WHAT IF I LATER WANT A DIFFERENT TYPE OF COVERAGE?

If you have been covered under this Policy for at least 6 months and decide you want coverage which:

- has comparable or lesser benefits (as described in the section above); and
- does not include the Medicare Select program,

you may then purchase any other Medicare Supplement policy we currently offer which meets your need.

When you apply for another policy, you will not have to provide us proof that your health is acceptable for insurance.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, A Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

You're covered for Hospital stays. You're covered for Skilled Nursing Facility stays. Remember, you're covered only for care that begins on or after your Coverage Date.

THE MEDICARE SELECT PROGRAM

We have arranged for the administration of your inpatient Hospital benefits through our Medicare Select program. Under this program, certain Hospitals have entered into a written agreement with us to provide services covered by this Policy. When you use the services of a Network Hospital, your benefits under this Policy will be greater.

As a participant in the Medicare Select program, you have received a directory of Network Hospitals. There may be changes in the directory listing. You will receive written notice of any changes to the Network Hospitals listed in the directory from time to time.

Although you may continue to go to the Hospital of your choice, remember that your benefits are greater when you use the services of a Network Hospital.

An applicant needs to live or reside in the Service Area in order to purchase this Policy.

WHAT DO WE MEAN BY "HOSPITAL"?

A Hospital is a properly licensed institution for care of the sick. It must:

- be supervised by a licensed Physician or staff of licensed Physicians;
- regularly provide bedside nursing by registered graduate professional nurses; and
- be approved by Medicare.

Rest homes or nursing homes are not considered Hospitals. Neither are institutions mainly offering:

- custodial, educational or rehabilitory care;
- care of the aged; or
- treatment for substance use disorder or alcoholism.

WHAT DO WE MEAN BY "SKILLED NURSING FACILITY"?

A Skilled Nursing Facility is a properly licensed institution, that:

- is approved for payment of Medicare benefits or qualified for approval of Medicare benefits;
- is supervised by a licensed Physician or a staff of licensed Physicians;
- provides 24-hour skilled nursing care by, or is supervised by, registered graduate nurses; and
- keeps a daily medical record for each patient.

Rest and retirement homes are not considered Skilled Nursing Facilities. Neither are institutions mainly offering:

- custodial or educational care;
- care of the aged;
- care and treatment of mental illness; or
- treatment for substance use disorder or alcoholism.

WHAT ARE MY HOSPICE AND INPATIENT RESPITE CARE BENEFITS?

Under this Policy:

- If the Member is receiving Hospice Care, Blue Cross and Blue Shield of Illinois will provide benefits for the cost sharing for all Part A Medicare Eligible Expenses and respite care expenses.
- We pay the cost of the Medicare Coinsurance/copayments.

WHAT ARE MY HOSPITAL BENEFITS IN A NETWORK HOSPITAL?

You will not have to pay your Part A Deductible when Medicare-approved services are received in a Network Hospital. In addition, we will pay the copayments you owe from the 61st through the 150th day of a stay in a Network Hospital. We will also pay for an additional 365 days of benefits beginning on the 151st day of your stay in a Network Hospital.

NOTE: THE PART A DEDUCTIBLE IS SHOWN IN THE OUTLINE OF COVERAGE PROVIDED AT THE TIME YOU PURCHASED THIS POLICY. AS CHANGES OCCUR TO THIS DEDUCTIBLE, WE WILL SEND YOU NOTICE, ALONG WITH INFORMATION REGARDING ANY OTHER BENEFIT CHANGES AFFECTING THE COVERAGE UNDER THIS POLICY.

WHAT ARE MY BENEFITS IN A NON-NETWORK HOSPITAL?

When Medicare-approved services are received in a Non-Network Hospital, we will pay the copayments you owe from the 61st through the 150th day of a stay in a Non-Network Hospital. We will also pay for an additional 365 days of benefits beginning on the 151st day of your Non-Network Hospital stay.

You will have to pay your Part A Deductible unless the Non-Network Hospital stay resulting from an emergency or was immediately required due to an unforeseen Sickness, injury or condition and it was not reasonable for you to obtain services from a Network Hospital.

HOW ARE MEDICARE BENEFIT PERIODS CALCULATED?

A benefit period begins on the first day you receive Inpatient Hospital Care and ends after you have been out of the Hospital and have not received care in a Skilled Nursing Facility for 60 days in a row.

WHAT COVERAGE DO I HAVE?

For Hospital Stays

When you enter the Hospital for a Medicare eligible admission, Medicare will pay for the first 60 days starting on the day you are admitted. Medicare will pay all of your eligible expenses for the first 60 days except for the Medicare Part A Deductible. **You will not have to pay the Part A Deductible if your Hospital stay is in a Network Hospital. You will have to pay the Part A Deductible for your stay in a Non-Network Hospital unless: the admission resulted from an emergency or was immediately required due to an unforeseen Sickness, injury or condition.**

If you are in the Hospital for more than 60 days, Medicare will no longer pay your covered expenses in full. From the 61st through the 90th day, Medicare covers all eligible expenses except for a certain amount which is deducted each day. The amount which is deducted each day is equal to $^1/_4$ of the Medicare Part A Deductible. The actual dollar amount is shown in your Outline of Coverage. **We pay this daily amount from the 61st day through the 90th day for you.**

Medicare will stop making payment after the 90th day unless you choose to use your Medicare reserve days. You have 60 Medicare reserve days. These are extra days available to you if you must be in the Hospital for more than 90 days. You may choose to use these days all at once or a few at a time. Once you use your reserve days, they are not renewed by Medicare.

If you choose to use your reserve days, Medicare will continue to pay all eligible expenses except for a certain amount which is deducted each day. The amount which is deducted each day is equal to 1/2 of the Medicare Part A Deductible. The actual dollar amount is shown in your Outline of Coverage. **We will pay this daily amount for you, even if you choose not to use your Medicare reserve days.**

We will pay this daily amount for you from the 91st day through the 150th day of your Hospital stay. Then we will pay 100% of the Medicare Eligible Expense beginning on the 151st day for an additional 365 days.

For Skilled Nursing Facility Confinement

To receive benefits for services in a Skilled Nursing Facility, you must have been in the Hospital for at least 3 days in a row (not counting the day of discharge) **before** you are admitted to the Skilled Nursing Facility. You also must be admitted to the Skilled Nursing Facility **within 30 days** from the date you are discharged from the Hospital.

Medicare will pay the first 20 days of your approved Skilled Nursing Facility stay in full.

Beginning on the 21st day through the 100th day, Medicare will pay all of your eligible expenses except for a certain amount which is deducted each day. This daily amount is equal to 1/8 of the Medicare Part A Deductible. The actual dollar amount is shown in your Outline of Coverage. **We pay this daily amount for you**.

For Hospice Care

To receive benefits for services for Hospice Care and inpatient respite care, you must meet Medicare's requirements, including a doctor's certification of terminal illness. You can receive benefits for a stay in a Medicare-approved facility, such as a Hospice facility, Hospital or nursing home, up to 5 days each time you get respite care.

Medicare will pay all of your approved Hospice Care in full with limited Coinsurance/copayments for Outpatient drugs and inpatient respite care.

We pay the cost of the Medicare Part A Coinsurance/copayment.

For Blood

When you need blood Medicare will pay the cost of all but the first 3 pints each year. **We pay the cost of the first 3 pints, if you do not replace the blood you received.**

WHAT INPATIENT HOSPITAL SERVICES ARE COVERED?

You're covered for all inpatient Hospital services. However, you must be admitted to the Hospital on or after your Coverage Date. Also, the services must be:

- Medically Necessary;
- approved by Medicare; and
- under a Physician's direction.

Typical inpatient charges are charges for bed and board or nursing care. You're covered for these charges and for other services, such as:

- use of operating and treatment rooms;
- inpatient drugs;
- surgical dressings;
- blood processing;
- diagnostic services; and
- administration of whole blood and blood components, when there is a charge.

WHAT DO WE MEAN BY ‘‘MEDICALLY NECESSARY’’?

The fact that your Physician orders a medical service does not always mean that the service is Medically Necessary or that the charge will be approved. By ‘‘Medically Necessary’’ we mean that the services:

- are required to diagnose or treat your Sickness or injury;
- meet generally accepted standards of medical practice; and
- are provided in the most cost-effective manner.

For Hospitalization to be Medically Necessary, you must need care that couldn’t be given to you as an Outpatient. A Hospitalization primarily for custodial care would not qualify for benefits.

For Medicare-approved services we will never use standards more restrictive than Medicare’s.

WHAT IF SERVICES ARE NOT AVAILABLE FROM A NETWORK HOSPITAL?

When you must receive inpatient services, which are not available from a Network Hospital, we will pay your Part A Deductible for a Medicare-approved stay in a Non-Network Hospital.

WHAT IF I NEED MEDICAL CARE IN A FOREIGN COUNTRY?

If you are in a Foreign country and receive emergency treatment during the first 60 days your trip, we will pay 80% of the eligible charges for Medically Necessary services. If you are Hospitalized due to an emergency, we will pay 80% of the eligible charges for Medically Necessary services as long as your Hospitalization occurred during the first 60 days of your trip.

Your benefits for the services you receive in a Foreign country are subject to a **$250.00** Calendar Year Deductible. You must pay this amount.

The total **lifetime benefit maximum** that we will pay for services received in a Foreign country is **$50,000.00**.

YOUR MEDICAL/SURGICAL BENEFITS

This section of your Policy describes benefits for services provided and charged for by a properly licensed medical professional or by a Hospital when rendered on an Outpatient basis. Charges must be approved by Medicare.

The Medicare Select program does not limit your choice of medical Providers under this benefit section.

HOW MANY TIMES MAY I GET BENEFITS WHEN I SEE MY PHYSICIAN?

You're covered for all Medicare approved visits. Most visits will be office appointments. However, we also cover house calls or visits a Physician makes to your Hospital or Skilled Nursing Facility. You're also covered for Emergency Care.

Visits for routine physicals aren't covered because Medicare doesn't cover them.

WHAT DOES THIS POLICY PAY?

After you pay your annual Medicare Part B Deductible, you will be entitled to the benefits described below.

1. The 20% Coinsurance amount (or in the case of Hospital Outpatient department services paid under a prospective payment system, the copayment amount) for such services, subject to:
   a. the lesser of a $20 copayment or the Medicare Part B Coinsurance or copayment for each covered health care Provider office visit (including visits to medical specialists); and
   b. the lesser of a $50 copayment or the Medicare Part B Coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any Hospital and the emergency visit is subsequently covered as a Medicare Part A expense.
2. The cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by Medicare) plus the 20% Coinsurance amount for the remainder of the Medicare Approved Amount for the cost of blood.

AM I COVERED FOR EMERGENCY CARE?

Yes, you're covered for Emergency Care if charges are approved by Medicare.

WHAT OTHER SERVICES ARE COVERED?

Examples of the types of services we pay are listed below. However, charges are covered only if they're approved by Medicare. We will pay 20% of the remaining Medicare Eligible Expense.

Surgery and anesthesia

You're covered for surgery in or out of the Hospital. This includes surgery in a properly licensed facility specializing in Outpatient surgery.

You're covered for anesthesia administered by a medical Provider other than the operating surgeon.

Oral surgery

Consultations

We'll pay for one second surgical opinion prior to elective surgery.

Pre-admission testing
If you're scheduled for inpatient surgery, we'll cover pre-admission testing if:

- surgery has been scheduled and your room reserved;
- testing is done by the Hospital personnel or a Physician's staff;
- the tests won't be repeated once you're admitted to the Hospital; and
- the tests would be covered by this Policy if they were done when you were an inpatient.

EEGs and EKGs

X-Rays
You're covered for x-rays ordered by a qualified professional.

Clinical and surgical pathology

Speech and physical therapy

Radiation and chemotherapy

Diagnostic services

Outpatient renal dialysis treatments
You're covered for treatments at a Hospital Outpatient, in a licensed dialysis facility or at home.

Mental health care
You're covered for Outpatient visits for the treatment of mental illness. Treatment may be in the Physician's office or Hospital Outpatient department.

Medical equipment
You're covered for the rental or purchase of medical equipment that you need.

You're also covered for internal or permanent devices, such as:

- cardiac valves,
- pacemakers,
- mandibular reconstruction devices, and
- leg, back, arm or neck braces.

Prosthetic devices
Purchase of cataract lenses, and the purchase and adjustments of prosthetic devices, are covered.

Ambulance service

Organ transplants
Human organ and tissue transplants are covered if you're the recipient.

Remember: These services are covered only when they are Medicare approved. After you pay your annual Medicare Part B Deductible, we pay 20% of the remaining Medicare Eligible Expense (the fee Medicare has decided is appropriate in your community for the service you receive).

WHAT IS THE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM?

The Outpatient prospective payment system consists of specific payment amounts, set by Medicare, for certain Outpatient services you receive from a Hospital, community mental health center, or other entity providing Outpatient services. Medicare has also set a specific copayment amount that must be paid for these services. Before receiving an Outpatient service you should check with your Physician or Hospital to see if it will be paid under the Outpatient prospective payment system.

HOW ARE SERVICES PAID UNDER THE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM?

We will pay the copayment amount under the Outpatient prospective payment system after you have paid the applicable deductible(s).

WHAT OTHER EXPENSES ARE NOT COVERED?

We pay only charges approved by MEDICARE. We won't pay for services and supplies that aren't specifically mentioned in this Policy. Other services we do not cover are:

—**Employment-related problems**

We don't pay for treatment of Accidental Injuries or Sickness if they're:

- related to work; or
- covered by an insurance or worker's compensation law.

This is true even if you decide not to claim benefits under the law.

—**Treatment covered or provided by Government Programs**

The only exception is for medical assistance under Article V, VI, or VII of the Illinois Public Aid Code.

—**Treatment for war-related injuries and Sickness**

This limitation applies to injuries and Sicknesses caused by war or acts of war, whether declared or undeclared.

—**Treatment provided by employers or unions**

This limitation applies to treatment received from medical and dental departments maintained by or for:

- an employer;
- a mutual benefit association;
- a labor union;
- a trustee; or
- a similar entity.

—**Free treatment**

We don't pay for free treatment, or treatment that would have been free if you were not insured under this Policy.

—**Custodial Care**

Custodial care means services which do not require technical skills or professional training. Assistance with activities of daily living (bathing, feeding, meal preparation) that is not a part of an approved at-home recovery benefit is an example of custodial care.

— **Services you no longer need**

— **Routine physical examinations**

— **Cosmetic surgery**

The only exception is for oral surgery.

— **Eye examinations**

We don't pay for eye exams or for eye glasses or contact lenses.

— **Hearing aids**

We don't pay for hearing aids or exams for their prescription and fitting.

— **Foot care**

We don't pay for routine foot care or the treatment of flat feet or subluxations of the foot.

— **Miscellaneous fees**

We don’t pay for fees charged to complete a claim form or because you didn’t keep a scheduled appointment.

— **Services from family members**

We don’t pay for services performed by a member of your immediate family.

— **Outpatient prescription drugs**

— **Private duty nursing services**

— **Amounts in excess of the Medicare Eligible Expense**

— **Preventive medical care**

MEDICARE SUPPLEMENT PREMIUMS

WHEN ARE MEDICARE SUPPLEMENT PREMIUMS DUE?

Your first Medicare Supplement Premium is due on the Effective Date of this Policy. Later Medicare Supplement Premiums are due on the first day of the Medicare Supplement Premium period. Medicare Supplement Premium periods and due dates are shown on your bill.

IN CASE OF DEATH

We'll refund unearned Medicare Supplement Premiums to your estate or authorized individual. A representative of your estate or authorized individual must send us a written request or call.

WHAT IF I'M LATE PAYING MY MEDICARE SUPPLEMENT PREMIUM?

After you have paid your first Medicare Supplement Premium you have a 31-day grace period after the due date to pay your future Medicare Supplement Premiums. You must pay before the grace period ends. If you don't, we won't pay benefits during those 31 days. We'll also cancel your Policy at the end of the grace period.

HOW ARE MY MEDICARE SUPPLEMENT PREMIUMS DETERMINED?

Your Medicare Supplement Premium may depend on your age, gender, Tobacco User status, and/or geographical location.

We may raise your Medicare Supplement Premiums if we increase your benefits under this Policy or your age category changes. When completing the application, you may need to make a gender selection. Additionally, if you meet the definition of a Tobacco User, you may pay a higher Medicare Supplement Premium for your health coverage. We may be required by law to add to your benefits, or we may increase them for another reason. We may also raise your Medicare Supplement Premium on any Policy anniversary or Medicare Supplement Premium due date.

If we raise Medicare Supplement Premiums for any reason, we'll give you 30 days prior written notice. We'll send any notice to you using the address on your application. Please notify us in writing or call 1-877-384-9297 if you change your address.

Premium Discounts

Blue Cross and Blue Shield of Illinois Medicare Supplement premium discounts 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 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 Blue Discount

You had commercial group or individual health insurance 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 Blue Cross and Blue Shield of Illinois Medicare Supplement policy becoming effective. Applies to Blue Cross and Blue Shield of Illinois Medicare Supplement policies issued with an effective date on or after April 1, 2022.

ADDITIONAL POLICY INFORMATION

HOW DO I USE MY ID CARD?

Present it when you receive medical services. Your ID Card shows your Policy number and the Effective Date of your Policy.

Do not lend your ID Card to anyone. If someone uses your ID Card, any payments we make may be credited against your benefits. We may, but are not required to, try to get the payment back.

CAN I CHOOSE MY PHYSICIAN AND HOSPITAL?

Yes. You select your Physician and all other medical Providers.

We don't recommend specific medical Providers. We aren't evaluating the quality or skill of a medical Provider when we report that the Provider:

- is or isn't approved by Medicare;
- is or isn't qualified by Medicare; or
- participates or doesn't participate in Medicare.

We will not furnish any medical service. We're not responsible if any Physician or other medical Provider refuses to serve you. We're also not responsible for any of their actions.

HOW DO I FILE CLAIMS?

Be sure to use your ID Card when you receive Hospital and medical services. This will speed up claims processing. Your Hospital and related Physician service claims will be sent to Medicare for you.

Medicare will send Your claims to Blue Cross and Blue Shield of Illinois for additional processing.

If you receive services from a Provider that does not accept Medicare Assignment and the Provider will not file claims on your behalf, you can obtain a Medicare claim forms by visiting www.Medicare.gov, or by contacting Medicare Customer Service, or from any Social Security office. The claim must be submitted to Medicare first. Once Medicare has processed, you will receive a Medicare Explanation of Benefits that will tell you what Medicare has paid. Send us a copy of the Medicare Explanation of Benefits within 60 days of receipt.

Be sure to print your Blue Cross and Blue Shield of Illinois ID number at the top. You'll find the number on your ID Card.

Please send it to:

Blue Cross and Blue Shield of Illinois
P. O. Box 2620
Chicago, IL 60690-2620

WHAT IF I CAN'T FILE MY CLAIM IN TIME?

File as soon as you can. We'll still process your claim up to 12 months or one Calendar Year, after the date of service, if you show us that:

- it wasn't reasonably possible to file earlier; and
- you filed as soon as you reasonably could.

WHO RECEIVES CLAIM PAYMENTS?

We'll usually pay your medical Provider if payment is due. Otherwise, we'll pay you.

You may **not** ask us not to pay your medical Provider for covered expenses. We won't be liable to you if we pay your expenses to your Provider after you ask us not to.

IN CASE OF DEATH

In case of your death, benefits owed to you, will be paid to your estate or authorized individual.

WHAT IF MY CLAIM IS DENIED?

You can call or write and request a review or verbal approval if we deny all or part of your claim. Write to:

Claim Review Section
Blue Cross and Blue Shield of Illinois
P.O. Box 2401
Chicago, Illinois 60690; or
call 1-877-384-9297

Be sure to write or call within 60 days of denial. Within 30 days of asking for a review, you may send more information or comments.

You may also review our records. However, you must make an appointment in writing to do so. You may have someone represent you. We must have your representative's name in writing. Within 60 days of your review request, we'll:

- send you our decision on the claim; or
- notify you that we'll need another 60 days.

A review may not take more than 120 days, even if you request it.

GRIEVANCE PROCEDURES

You have a right to submit a Grievance to us if you are dissatisfied with any aspect of processing your coverage. Write to us at the following address within 60 days of the date you are notified of any adverse action:

Grievance Committee
Blue Cross and Blue Shield of Illinois
Medicare Select Program
Direct Markets
P. O. Box 1637
Chicago, Illinois 60690-1637

Your Grievance will be reviewed by a committee comprised of Blue Cross and Blue Shield of Illinois technical and management personnel who have authority to take corrective action, if warranted.

Unless additional information from an outside source is required to complete our review, we'll send you a response within 30 days of receipt of your Grievance.

If we determine that additional information from an outside source is required to complete our review, we'll notify you within 30 days of this determination. An additional 30 days may be required to finalize, research and respond to your Grievance. In any case, a response will be sent to you within 60 days of receipt of your Grievance.

DEPARTMENT OF INSURANCE ADDRESSES

You may discuss your claim with the Department of Insurance. The addresses of the Department's Consumer Divisions are:

Illinois Department of Insurance
122 South Michigan Ave., 19th Floor
Chicago, Illinois 60603

or

Illinois Department of Insurance
Consumer Services Section
320 West Washington Street
Springfield, Illinois 62767

CAN I ASSIGN MY COVERAGE?

No. Rights under this Policy aren't assignable. That means you can't give your rights to someone else. You'll lose your coverage if you allow someone else to claim benefits under your Policy.

DO YOU EXCHANGE MEDICAL INFORMATION ABOUT ME?

Yes. We may exchange medical information with:

- anyone who provides medical services and supplies to you;
- other Blue Cross or Blue Shield plans;
- other insurance companies;
- employee benefit associations;
- governmental bodies or programs; or
- any other person or group (only for the purpose of processing and paying claims).

We may only ask about or give information on:

- a problem for which you're claiming benefits;
- your medical history, if relevant; or
- any benefits you've received.

WHAT ABOUT MISSTATEMENTS ON MY APPLICATION?

If a misstatement on your application affects your coverage, we'll use the correct fact to decide your benefits.

Medicare Supplement Premiums are based on your correct age, gender, Tobacco User status and/or geographical location. If you've misstated your age, Tobacco User status and/or geographical location and the correct Medicare Supplement Premium is more than you've been paying, you'll have to pay us the amount due from the date your coverage began.

WHAT LIMITS ARE THERE ON LEGAL ACTION?

If we deny a claim, you may choose to sue us for benefits. However, you can't sue until 60 days after a claim denial. You must sue within three years of a claim denial.

If we extend the time allowed for filing a claim, that extension won't affect these limits.

MAY I VOTE AT THE ANNUAL MEETING?

Yes. Our annual meetings are scheduled to be held at 12:30 p.m. on the last Tuesday in October. They're held at our main office:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601-5099

You may vote in person or by proxy (a person you have selected to represent you).

BlueCross BlueShield
of Illinois

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