



Applicant's Name _____

Name of Existing Insurer _____ **Expiration Date of Existing Insurance** ____/____/____

Medicare Supplement Plans: Important — You **must** indicate your choice of coverage. **Mark only one box, please.**

Plan K Standard Med-Select
(Annual out-of-pocket limit of \$4,620)

Plan L Standard Med-Select
(Annual out-of-pocket limit of \$2,310)

SERVICE	BENEFIT	MEDICARE PAYS	EXISTING COVERAGE PAYS	SUPPLEMENT COVERS	YOU PAY
HOSPITAL INPATIENT SERVICES	Days 1-60	All but \$ 1,100		<input type="checkbox"/> Plan K: \$550 Part A Deductible* <input type="checkbox"/> Plan L: \$825 Part A Deductible*	<input type="checkbox"/> Plan K: \$550 Part A deductible <input type="checkbox"/> Plan L: \$275 Part A deductible
	Days 61-90	All but \$275 a day		\$275 a day	\$0
	Days 91-150 (Lifetime Reserve)	All but \$550 a day		\$550 a day	\$0
	Days 151 and beyond	\$0		All Medicare-approved amounts for an additional 365 days	\$0
SKILLED NURSING HOME CARE	Days 1-20	All costs		\$0	\$0
	Days 21-100	All but \$137.50 a day		<input type="checkbox"/> Plan K: \$68.75 a day <input type="checkbox"/> Plan L: \$103.12 a day	<input type="checkbox"/> Plan K: \$68.75 a day <input type="checkbox"/> Plan L: \$34.38 a day
	Days 101 and beyond	\$0		\$0	All costs
MEDICAL EXPENSES	Physician's Services in hospital, office, or home; inpatient and outpatient medical services and supplies at a hospital; physical and speech therapy; and ambulance	80% of the Medicare-determined allowable charges after a \$155 deductible per calendar year		<input type="checkbox"/> After \$155 Medicare Calendar Year deductible, Plan K generally pays 10% and Plan L generally pays 15% of Medicare-approved amounts	Charges not covered by policy and Medicare
PRESCRIPTION DRUGS		Inpatient Prescription Drugs — 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant		No benefit	All costs; outpatient drugs

This policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

Date ____/____/____

Signature of Applicant **X** _____

Signature of Producer **X** _____

* Med-Select Plans require that you use Blue Cross and Blue Shield of Illinois participating Med-Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible.

WHITE: RETURN WITH APPLICATION • YELLOW: FOR CLIENT'S RECORDS