



**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 A**  Standard      **Plan C**  Standard  Med-Select      **Plan F**  Standard      **Plan G**  Standard  Med-Select  
**Plan B**  Standard  Med-Select      **Plan F**  Standard  Med-Select      (High Deductible)\*\*      **Plan N**  Standard  Med-Select

SERVICE	BENEFIT	MEDICARE PAYS	EXISTING COVERAGE PAYS	SUPPLEMENT COVERS	YOU PAY
<b>HOSPITAL INPATIENT SERVICES</b>	Days 1-60	All but \$1,156		<input type="checkbox"/> \$1,156 Part A Deductible* <b>or</b> <input type="checkbox"/> \$0 Plan A Only	<input type="checkbox"/> \$0 <b>or</b> <input type="checkbox"/> \$1,156 Part A Deductible
	Days 61-90	All but \$289 a day		\$289 a day	\$0
	Days 91-150 (Lifetime Reserve)	All but \$578 a day		\$578 a day	\$0
	Days 151 and beyond	\$0		All Medicare-approved amounts for an additional 365 days	\$0
<b>SKILLED NURSING HOME CARE</b>	Days 1-20 (All Plans)	All costs		\$0	\$0
	Days 21-100	All but \$144.50 a day		<input type="checkbox"/> \$144.50 a day <b>or</b> <input type="checkbox"/> \$0 Plans A, B	<input type="checkbox"/> \$0 <b>or</b> <input type="checkbox"/> \$ 144.50 a day
	Days 101 and beyond (All Plans)	\$0		\$0	All costs
<b>MEDICAL EXPENSES</b>	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 \$140 deductible per calendar year		<input type="checkbox"/> After \$140 Medicare Part B Deductible per calendar year, 20% of Medicare-approved amounts for Plans A,B,C,F,High F,G <input type="checkbox"/> After \$140 Medicare Part B Deductible per calendar year Plan N pays the 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 <input type="checkbox"/> \$140 Part B deductible for Plans C, F, High F <input type="checkbox"/> 100% Part B Excess Charges for Plans F, High F and G	Charges not covered by policy and Medicare  <input type="checkbox"/> \$140 Part B deductible for Plans A, B, G, N <input type="checkbox"/> Part B Excess Charges for Plans A, B, C, N
<b>PRESCRIPTION DRUGS</b>		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.

\*\***High Deductible Plan F** offers the same benefits as Plan F after you have paid a \$2,070 calendar-year deductible.