

2010 Policy Checklist

Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance _____ / _____ / _____



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

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

Plan A Standard

Plan F Standard Med-Select

Plan B Standard Med-Select

Plan F (High Deductible) Standard

Plan C Standard Med-Select

Plan D Standard Med-Select

High Deductible Plan F offers the same benefits as Plan F after you have paid a \$2,000 calendar-year deductible.

Plan E Standard Med-Select

| SERVICE | BENEFIT | MEDICARE PAYS | EXISTING COVERAGE PAYS | SUPPLEMENT COVERS | YOU PAY |
|-----------------------------|---|--|------------------------|--|---|
| HOSPITAL INPATIENT SERVICES | Days 1-60 | All but \$1,100 | | <input type="checkbox"/> \$1,100 Part A Deductible* or <input type="checkbox"/> \$0 | <input type="checkbox"/> \$1,100 Part A Deductible or <input type="checkbox"/> \$0* |
| | 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 | |
| | Days 21-100 | All but \$137.50 a day | | <input type="checkbox"/> \$137.50 a day or <input type="checkbox"/> \$0 | <input type="checkbox"/> \$137.50 a day or <input type="checkbox"/> \$0 |
| | 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 | | For charges covered under Part B Medicare: <input type="checkbox"/> After \$155 Medicare Calendar Year deductible, 20% of Medicare allowable charges <input type="checkbox"/> Part B Deductible <input type="checkbox"/> 100% Part B Excess Charges | 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.**