



This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be 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.**

Note: A ✓ means 100% of the benefit is paid

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G <sup>1</sup>	K <sup>2</sup>	L <sup>2</sup>	M	N	C	F <sup>1</sup>
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	copays apply <sup>3</sup>	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2025 <sup>2</sup>					\$7,220 <sup>2</sup>	\$3,610 <sup>2</sup>				

- <sup>1</sup> Plans F and G also have a high deductible option which require first paying a plan deductible of \$2,870 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.
- <sup>2</sup> Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.
- <sup>3</sup> Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.

## Monthly Premium Rates effective April 1, 2025

Rates shown are for Illinois residents living outside Cook, DuPage, Kane, Lake, McHenry and Will Counties.

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

<b>Age 65</b>				
	<b>FEMALE</b>		<b>MALE</b>	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$138.87	\$126.24	\$159.63	\$145.13
<b>F</b>	\$189.91	\$172.66	\$218.31	\$198.46
<b>F Plus</b>	\$213.30	\$196.05	\$241.70	\$221.85
<b>G</b>	\$162.06	\$147.34	\$186.28	\$169.36
<b>G Plus</b>	\$185.45	\$170.73	\$209.67	\$192.75
<b>N</b>	\$118.79	\$108.00	\$136.54	\$124.14
<b>N Plus</b>	\$142.18	\$131.39	\$159.93	\$147.53

<b>Age 66</b>				
	<b>FEMALE</b>		<b>MALE</b>	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$138.87	\$126.24	\$159.63	\$145.13
<b>F</b>	\$189.91	\$172.66	\$218.31	\$198.46
<b>F Plus</b>	\$213.30	\$196.05	\$241.70	\$221.85
<b>G</b>	\$162.06	\$147.34	\$186.28	\$169.36
<b>G Plus</b>	\$185.45	\$170.73	\$209.67	\$192.75
<b>N</b>	\$118.79	\$108.00	\$136.54	\$124.14
<b>N Plus</b>	\$142.18	\$131.39	\$159.93	\$147.53

# Age 67

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$138.87	\$126.24	\$159.63	\$145.13
<b>F</b>	\$189.91	\$172.66	\$218.31	\$198.46
<b>F Plus</b>	\$213.30	\$196.05	\$241.70	\$221.85
<b>G</b>	\$162.06	\$147.34	\$186.28	\$169.36
<b>G Plus</b>	\$185.45	\$170.73	\$209.67	\$192.75
<b>N</b>	\$118.79	\$108.00	\$136.54	\$124.14
<b>N Plus</b>	\$142.18	\$131.39	\$159.93	\$147.53

# Age 68

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$146.23	\$132.95	\$168.08	\$152.80
<b>F</b>	\$197.48	\$179.55	\$226.99	\$206.35
<b>F Plus</b>	\$220.87	\$202.94	\$250.38	\$229.74
<b>G</b>	\$170.46	\$154.96	\$195.92	\$178.11
<b>G Plus</b>	\$193.85	\$178.35	\$219.31	\$201.50
<b>N</b>	\$125.20	\$113.82	\$143.91	\$130.84
<b>N Plus</b>	\$148.59	\$137.21	\$167.30	\$154.23

# Age 69

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$154.40	\$140.36	\$177.48	\$161.35
<b>F</b>	\$206.74	\$187.94	\$237.63	\$216.03
<b>F Plus</b>	\$230.13	\$211.33	\$261.02	\$239.42
<b>G</b>	\$179.75	\$163.42	\$206.65	\$187.86
<b>G Plus</b>	\$203.14	\$186.81	\$230.04	\$211.25
<b>N</b>	\$132.51	\$120.47	\$152.32	\$138.47
<b>N Plus</b>	\$155.90	\$143.86	\$175.71	\$161.86

# Age 70

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$162.57	\$147.81	\$186.86	\$169.88
<b>F</b>	\$216.81	\$197.11	\$249.21	\$226.56
<b>F Plus</b>	\$240.20	\$220.50	\$272.60	\$249.95
<b>G</b>	\$190.01	\$172.75	\$218.41	\$198.55
<b>G Plus</b>	\$213.40	\$196.14	\$241.80	\$221.94
<b>N</b>	\$139.81	\$127.12	\$160.71	\$146.10
<b>N Plus</b>	\$163.20	\$150.51	\$184.10	\$169.49

# Age 71

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$170.73	\$155.21	\$196.24	\$178.41
<b>F</b>	\$227.73	\$207.04	\$261.76	\$237.98
<b>F Plus</b>	\$251.12	\$230.43	\$285.15	\$261.37
<b>G</b>	\$200.27	\$182.06	\$230.19	\$209.26
<b>G Plus</b>	\$223.66	\$205.45	\$253.58	\$232.65
<b>N</b>	\$147.13	\$133.74	\$169.12	\$153.75
<b>N Plus</b>	\$170.52	\$157.13	\$192.51	\$177.14

# Age 72

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$178.10	\$161.90	\$204.71	\$186.10
<b>F</b>	\$238.67	\$216.98	\$274.33	\$249.40
<b>F Plus</b>	\$262.06	\$240.37	\$297.72	\$272.79
<b>G</b>	\$210.53	\$191.38	\$241.98	\$219.97
<b>G Plus</b>	\$233.92	\$214.77	\$265.37	\$243.36
<b>N</b>	\$154.42	\$140.39	\$177.51	\$161.39
<b>N Plus</b>	\$177.81	\$163.78	\$200.90	\$184.78

# Age 73

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$185.43	\$168.59	\$213.14	\$193.78
<b>F</b>	\$248.75	\$226.15	\$285.91	\$259.94
<b>F Plus</b>	\$272.14	\$249.54	\$309.30	\$283.33
<b>G</b>	\$219.82	\$199.84	\$252.65	\$229.70
<b>G Plus</b>	\$243.21	\$223.23	\$276.04	\$253.09
<b>N</b>	\$161.76	\$147.05	\$185.92	\$169.02
<b>N Plus</b>	\$185.15	\$170.44	\$209.31	\$192.41

# Age 74

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$191.96	\$174.53	\$220.66	\$200.61
<b>F</b>	\$258.84	\$235.31	\$297.52	\$270.47
<b>F Plus</b>	\$282.23	\$258.70	\$320.91	\$293.86
<b>G</b>	\$229.12	\$208.30	\$263.38	\$239.44
<b>G Plus</b>	\$252.51	\$231.69	\$286.77	\$262.83
<b>N</b>	\$169.06	\$153.70	\$194.33	\$176.67
<b>N Plus</b>	\$192.45	\$177.09	\$217.72	\$200.06

# Age 75

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$198.50	\$180.47	\$228.20	\$207.44
<b>F</b>	\$268.90	\$244.47	\$309.10	\$281.01
<b>F Plus</b>	\$292.29	\$267.86	\$332.49	\$304.40
<b>G</b>	\$238.43	\$216.77	\$274.08	\$249.18
<b>G Plus</b>	\$261.82	\$240.16	\$297.47	\$272.57
<b>N</b>	\$176.37	\$160.35	\$202.74	\$184.31
<b>N Plus</b>	\$199.76	\$183.74	\$226.13	\$207.70

# Age 76

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$204.24	\$185.68	\$234.75	\$213.41
<b>F</b>	\$278.17	\$252.88	\$319.74	\$290.67
<b>F Plus</b>	\$301.56	\$276.27	\$343.13	\$314.06
<b>G</b>	\$247.77	\$225.24	\$284.79	\$258.91
<b>G Plus</b>	\$271.16	\$248.63	\$308.18	\$282.30
<b>N</b>	\$182.78	\$166.17	\$210.07	\$190.98
<b>N Plus</b>	\$206.17	\$189.56	\$233.46	\$214.37

# Age 77

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$209.93	\$190.85	\$241.31	\$219.39
<b>F</b>	\$287.40	\$261.27	\$330.36	\$300.32
<b>F Plus</b>	\$310.79	\$284.66	\$353.75	\$323.71
<b>G</b>	\$256.13	\$232.86	\$294.41	\$267.66
<b>G Plus</b>	\$279.52	\$256.25	\$317.80	\$291.05
<b>N</b>	\$189.17	\$171.99	\$217.43	\$197.67
<b>N Plus</b>	\$212.56	\$195.38	\$240.82	\$221.06

# Age 78

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$214.85	\$195.33	\$246.96	\$224.50
<b>F</b>	\$295.81	\$268.92	\$340.01	\$309.10
<b>F Plus</b>	\$319.20	\$292.31	\$363.40	\$332.49
<b>G</b>	\$264.54	\$240.48	\$304.07	\$276.44
<b>G Plus</b>	\$287.93	\$263.87	\$327.46	\$299.83
<b>N</b>	\$195.57	\$177.78	\$224.78	\$204.35
<b>N Plus</b>	\$218.96	\$201.17	\$248.17	\$227.74

# Age 79

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$218.94	\$199.04	\$251.64	\$228.77
F	\$304.21	\$276.55	\$349.69	\$317.90
F Plus	\$327.60	\$299.94	\$373.08	\$341.29
G	\$271.99	\$247.27	\$312.63	\$284.21
G Plus	\$295.38	\$270.66	\$336.02	\$307.60
N	\$201.96	\$183.60	\$232.15	\$211.05
N Plus	\$225.35	\$206.99	\$255.54	\$234.44

# Age 80

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$224.97	\$204.53	\$258.59	\$235.09
F	\$312.21	\$283.83	\$358.86	\$326.25
F Plus	\$335.60	\$307.22	\$382.25	\$349.64
G	\$279.52	\$254.11	\$321.30	\$292.11
G Plus	\$302.91	\$277.50	\$344.69	\$315.50
N	\$207.58	\$188.71	\$238.58	\$216.90
N Plus	\$230.97	\$212.10	\$261.97	\$240.29

# Age 81

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$230.90	\$209.91	\$265.39	\$241.28
F	\$320.02	\$290.92	\$367.85	\$334.41
F Plus	\$343.41	\$314.31	\$391.24	\$357.80
G	\$286.92	\$260.83	\$329.80	\$299.82
G Plus	\$310.31	\$284.22	\$353.19	\$323.21
N	\$213.05	\$193.69	\$244.90	\$222.64
N Plus	\$236.44	\$217.08	\$268.29	\$246.03



## Age 82

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$236.67	\$215.15	\$272.03	\$247.31
F	\$327.64	\$297.86	\$376.59	\$342.38
F Plus	\$351.03	\$321.25	\$399.98	\$365.77
G	\$294.13	\$267.38	\$338.06	\$307.33
G Plus	\$317.52	\$290.77	\$361.45	\$330.72
N	\$218.39	\$198.55	\$251.05	\$228.22
N Plus	\$241.78	\$221.94	\$274.44	\$251.61

## Age 83

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$242.31	\$220.29	\$278.51	\$253.20
F	\$335.04	\$304.59	\$385.11	\$350.11
F Plus	\$358.43	\$327.98	\$408.50	\$373.50
G	\$301.13	\$273.76	\$346.14	\$314.68
G Plus	\$324.52	\$297.15	\$369.53	\$338.07
N	\$223.61	\$203.30	\$257.03	\$233.67
N Plus	\$247.00	\$226.69	\$280.42	\$257.06

## Age 84

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$247.82	\$225.28	\$284.84	\$258.93
F	\$342.27	\$311.16	\$393.44	\$357.67
F Plus	\$365.66	\$334.55	\$416.83	\$381.06
G	\$307.96	\$279.97	\$353.98	\$321.81
G Plus	\$331.35	\$303.36	\$377.37	\$345.20
N	\$228.68	\$207.90	\$262.88	\$238.99
N Plus	\$252.07	\$231.29	\$286.27	\$262.38

# Age 85

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$253.14	\$230.13	\$290.98	\$264.53
<b>F</b>	\$349.33	\$317.57	\$401.52	\$365.03
<b>F Plus</b>	\$372.72	\$340.96	\$424.91	\$388.42
<b>G</b>	\$314.63	\$286.02	\$361.64	\$328.77
<b>G Plus</b>	\$338.02	\$309.41	\$385.03	\$352.16
<b>N</b>	\$233.65	\$212.41	\$268.55	\$244.15
<b>N Plus</b>	\$257.04	\$235.80	\$291.94	\$267.54

# Age 86

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$258.35	\$234.87	\$296.96	\$269.97
<b>F</b>	\$356.18	\$323.80	\$409.39	\$372.18
<b>F Plus</b>	\$379.57	\$347.19	\$432.78	\$395.57
<b>G</b>	\$321.10	\$291.91	\$369.08	\$335.53
<b>G Plus</b>	\$344.49	\$315.30	\$392.47	\$358.92
<b>N</b>	\$238.44	\$216.78	\$274.06	\$249.15
<b>N Plus</b>	\$261.83	\$240.17	\$297.45	\$272.54

# Age 87

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$263.41	\$239.46	\$302.77	\$275.25
<b>F</b>	\$362.85	\$329.86	\$417.05	\$379.14
<b>F Plus</b>	\$386.24	\$353.25	\$440.44	\$402.53
<b>G</b>	\$327.42	\$297.65	\$376.32	\$342.12
<b>G Plus</b>	\$350.81	\$321.04	\$399.71	\$365.51
<b>N</b>	\$243.13	\$221.03	\$279.46	\$254.05
<b>N Plus</b>	\$266.52	\$244.42	\$302.85	\$277.44

# Age 88

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$268.34	\$243.95	\$308.45	\$280.41
<b>F</b>	\$369.30	\$335.73	\$424.48	\$385.89
<b>F Plus</b>	\$392.69	\$359.12	\$447.87	\$409.28
<b>G</b>	\$333.52	\$303.21	\$383.35	\$348.52
<b>G Plus</b>	\$356.91	\$326.60	\$406.74	\$371.91
<b>N</b>	\$247.67	\$225.17	\$284.67	\$258.80
<b>N Plus</b>	\$271.06	\$248.56	\$308.06	\$282.19

# Age 89

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$273.14	\$248.31	\$313.96	\$285.42
<b>F</b>	\$375.58	\$341.45	\$431.72	\$392.49
<b>F Plus</b>	\$398.97	\$364.84	\$455.11	\$415.88
<b>G</b>	\$339.46	\$308.60	\$390.17	\$354.69
<b>G Plus</b>	\$362.85	\$331.99	\$413.56	\$378.08
<b>N</b>	\$252.08	\$229.15	\$289.74	\$263.41
<b>N Plus</b>	\$275.47	\$252.54	\$313.13	\$286.80

# Age 90

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$277.78	\$252.53	\$319.27	\$290.25
<b>F</b>	\$381.68	\$347.00	\$438.71	\$398.83
<b>F Plus</b>	\$405.07	\$370.39	\$462.10	\$422.22
<b>G</b>	\$345.23	\$313.85	\$396.81	\$360.75
<b>G Plus</b>	\$368.62	\$337.24	\$420.20	\$384.14
<b>N</b>	\$256.35	\$233.05	\$294.66	\$267.87
<b>N Plus</b>	\$279.74	\$256.44	\$318.05	\$291.26

# Age 91

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$282.27	\$256.63	\$324.45	\$294.96
F	\$387.59	\$352.36	\$445.49	\$405.00
F Plus	\$410.98	\$375.75	\$468.88	\$428.39
G	\$350.80	\$318.92	\$403.21	\$366.56
G Plus	\$374.19	\$342.31	\$426.60	\$389.95
N	\$260.50	\$236.81	\$299.42	\$272.21
N Plus	\$283.89	\$260.20	\$322.81	\$295.60

# Age 92

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$286.64	\$260.58	\$329.47	\$299.52
F	\$393.28	\$357.54	\$452.06	\$410.97
F Plus	\$416.67	\$380.93	\$475.45	\$434.36
G	\$356.18	\$323.80	\$409.41	\$372.20
G Plus	\$379.57	\$347.19	\$432.80	\$395.59
N	\$264.50	\$240.45	\$304.03	\$276.40
N Plus	\$287.89	\$263.84	\$327.42	\$299.79

# Age 93

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$290.85	\$264.42	\$334.32	\$303.93
F	\$398.81	\$362.56	\$458.38	\$416.72
F Plus	\$422.20	\$385.95	\$481.77	\$440.11
G	\$361.40	\$328.55	\$415.41	\$377.66
G Plus	\$384.79	\$351.94	\$438.80	\$401.05
N	\$268.37	\$243.98	\$308.48	\$280.44
N Plus	\$291.76	\$267.37	\$331.87	\$303.83

# Age 94

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$294.92	\$268.13	\$338.98	\$308.18
<b>F</b>	\$404.13	\$367.39	\$464.51	\$422.29
<b>F Plus</b>	\$427.52	\$390.78	\$487.90	\$445.68
<b>G</b>	\$366.45	\$333.13	\$421.20	\$382.92
<b>G Plus</b>	\$389.84	\$356.52	\$444.59	\$406.31
<b>N</b>	\$272.11	\$247.38	\$312.80	\$284.37
<b>N Plus</b>	\$295.50	\$270.77	\$336.19	\$307.76

# Age 95

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$298.88	\$271.71	\$343.55	\$312.31
<b>F</b>	\$409.27	\$372.07	\$470.42	\$427.67
<b>F Plus</b>	\$432.66	\$395.46	\$493.81	\$451.06
<b>G</b>	\$371.30	\$337.55	\$426.79	\$387.98
<b>G Plus</b>	\$394.69	\$360.94	\$450.18	\$411.37
<b>N</b>	\$275.71	\$250.65	\$316.93	\$288.11
<b>N Plus</b>	\$299.10	\$274.04	\$340.32	\$311.50

# Age 96

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
<b>A</b>	\$302.67	\$275.17	\$347.92	\$316.29
<b>F</b>	\$414.20	\$376.55	\$476.08	\$432.82
<b>F Plus</b>	\$437.59	\$399.94	\$499.47	\$456.21
<b>G</b>	\$375.98	\$341.81	\$432.15	\$392.87
<b>G Plus</b>	\$399.37	\$365.20	\$455.54	\$416.26
<b>N</b>	\$279.19	\$253.81	\$320.93	\$291.77
<b>N Plus</b>	\$302.58	\$277.20	\$344.32	\$315.16

# Age 97

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$306.35	\$278.50	\$352.12	\$320.12
F	\$418.98	\$380.88	\$481.58	\$437.81
F Plus	\$442.37	\$404.27	\$504.97	\$461.20
G	\$380.46	\$345.88	\$437.32	\$397.57
G Plus	\$403.85	\$369.27	\$460.71	\$420.96
N	\$282.53	\$256.85	\$324.75	\$295.23
N Plus	\$305.92	\$280.24	\$348.14	\$318.62

# Age 98

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$309.86	\$281.69	\$356.17	\$323.79
F	\$423.52	\$385.04	\$486.81	\$442.56
F Plus	\$446.91	\$408.43	\$510.20	\$465.95
G	\$384.78	\$349.81	\$442.30	\$402.08
G Plus	\$408.17	\$373.20	\$465.69	\$425.47
N	\$285.73	\$259.77	\$328.44	\$298.58
N Plus	\$309.12	\$283.16	\$351.83	\$321.97

# Age 99

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$313.22	\$284.75	\$360.02	\$327.30
F	\$427.92	\$389.03	\$491.86	\$447.15
F Plus	\$451.31	\$412.42	\$515.25	\$470.54
G	\$388.93	\$353.58	\$447.04	\$406.41
G Plus	\$412.32	\$376.97	\$470.43	\$429.80
N	\$288.82	\$262.57	\$331.98	\$301.80
N Plus	\$312.21	\$285.96	\$355.37	\$325.19

# Age 100 +

	FEMALE		MALE	
	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco
A	\$316.46	\$287.69	\$363.76	\$330.70
F	\$432.08	\$392.82	\$496.67	\$451.53
F Plus	\$455.47	\$416.21	\$520.06	\$474.92
G	\$392.89	\$357.17	\$451.60	\$410.54
G Plus	\$416.28	\$380.56	\$474.99	\$433.93
N	\$291.75	\$265.22	\$335.35	\$304.87
N Plus	\$315.14	\$288.61	\$358.74	\$328.26

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 BCBSIL Medicare Supplement plan. Discounts cannot be combined; only one type of discount per member is 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 BCBSIL Medicare Supplement policies issued with an effective date on or after May 1, 2019. The discount is 10%.

### **Continue with Blue<sup>SM</sup> Discount**

You may be eligible for a discount if you enrolled in a BCBSIL Medicare Supplement policy issued with an effective date on or after April 1, 2022 and you were enrolled in a Blue Cross and Blue Shield commercial group or individual health insurance coverage plan and that coverage was within one year of your BCBSIL Medicare Supplement policy becoming effective. The discount is 7%.

### **Blue Family Discount<sup>SM</sup>**

You may be eligible for a discount if you enrolled in a BCBSIL Medicare Supplement policy issued with an effective date on or after April 1, 2024 and you meet the criteria for both the Household Discount AND the Continue with Blue Discount. The discount is 12%.



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## 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 Supplement™ 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
<b>Hospitalization<sup>4</sup></b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$0	\$1,676 (Part A deductible)
61st through 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$838 a day	\$838 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 <sup>5</sup>
Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care<sup>4</sup></b> 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 \$209.50 a day	\$0	Up to \$209.50 a day
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b> 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

<sup>4</sup> 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.

<sup>5</sup> 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
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$0	\$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$0	\$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services — Tests for Diagnostic Services</b>	100%	\$0	\$0

## MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan A Pays	You Pay
<b>Home Health Care Medicare-approved Services</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$0	\$257 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

<sup>6</sup> Once you have been billed \$257 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
<b>Hospitalization<sup>4</sup></b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A deductible)	\$0
61st through 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$838 a day	\$838 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 <sup>5</sup>
Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care<sup>4</sup></b> 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 \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b> 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
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$257 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$257 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services — Tests for Diagnostic Services</b>	100%	\$0	\$0
<b>MEDICARE (PARTS A &amp; B)</b>			
Services	Medicare Pays	Plan F Pays	You Pay
<b>Home Health Care Medicare-approved Services</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$257 (Part B deductible)	\$0
– Remainder of Medicare-approved amounts	80%	20%	\$0
<b>OTHER BENEFITS – NOT COVERED BY MEDICARE</b>			
<b>Foreign Travel — Not Covered by Medicare</b> 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 F Plus

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

Services	Medicare Pays	Plan F Plus Pays	You Pay
<b>Hospitalization<sup>4</sup></b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A deductible)	\$0
61st through 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$838 a day	\$838 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 <sup>5</sup>
Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care<sup>4</sup></b> 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 \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b> 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 Plus

## MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

Services	Medicare Pays	Plan F Plus Pays	You Pay
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$257 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$257 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services — Tests for Diagnostic Services</b>	100%	\$0	\$0

## MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan F Plus Pays	You Pay
<b>Home Health Care Medicare-approved Services</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$257 (Part B deductible)	\$0
– Remainder of Medicare-approved amounts	80%	20%	\$0

## OTHER BENEFITS – NOT COVERED BY MEDICARE

<b>Foreign Travel — Not Covered by Medicare</b> 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 F Plus

## INNOVATIVE BENEFITS

### DENTAL

Services	Medicare Pays	Plan F Plus Pays	You Pay
<b>Diagnostic Evaluations</b>			
In Network	\$0	100%	\$0
Out of Network	\$0	50%	50%
<b>Preventive Services</b>			
In Network	\$0	100%	\$0
Out of Network	\$0	50%	50%
<b>Diagnostic Radiographs</b>			
In Network	\$0	100%	\$0
Out of Network	\$0	50%	50%
<b>Basic Restorative Services<sup>7</sup></b>	\$0	50%	50%
<b>Non-Surgical Extractions</b>			
In Network	\$0	75%	25%
Out of Network	\$0	50%	50%
<b>VISION</b>			
Services	Medicare Pays	Plan F Plus Pays	You Pay
<b>Annual Routine Examination</b>			
In Network	\$0	100%	\$0
Out of Network	\$0	All except \$40	\$40
<b>Materials Allowance</b>			
In Network	\$0	\$130	Remaining Balance
Out of Network	\$0	\$65	Remaining Balance
<b>HEARING<sup>8</sup></b>			
Services	Medicare Pays	Plan F Plus Pays	You Pay
<b>Annual Routine Examination</b>	\$0	100%	\$0
<b>Hardware Discounts</b>	\$0	Generally 30%	Remaining Balance

<sup>7</sup> Once per tooth per calendar year.

<sup>8</sup> All services must be received in network.



# Plan G

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

Services	Medicare Pays	Plan G Pays	You Pay
<b>Hospitalization<sup>4</sup></b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A deductible)	\$0
61st through 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$838 a day	\$838 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 <sup>5</sup>
Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care<sup>4</sup></b> 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 \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b> 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
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$0	\$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$0	\$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services — Tests for Diagnostic Services</b>	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 \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$0	\$257 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

## OTHER BENEFITS - NOT COVERED BY MEDICARE

<b>Foreign Travel — Not Covered by Medicare</b> 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
<b>Hospitalization<sup>4</sup></b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A deductible)	\$0
61st through 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$838 a day	\$838 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 <sup>5</sup>
Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care<sup>4</sup></b> 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 \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b> 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
<b>Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment</b> , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$0	\$257 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$0	\$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services — Tests for Diagnostic Services</b>	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 \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$0	\$257 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

## OTHER BENEFITS - NOT COVERED BY MEDICARE

<b>Foreign Travel — Not Covered by Medicare</b> 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
<b>Diagnostic Evaluations</b>			
In Network	\$0	100%	\$0
Out of Network	\$0	50%	50%
<b>Preventive Services</b>			
In Network	\$0	100%	\$0
Out of Network	\$0	50%	50%
<b>Diagnostic Radiographs</b>			
In Network	\$0	100%	\$0
Out of Network	\$0	50%	50%
<b>Basic Restorative Services<sup>7</sup></b>	\$0	50%	50%
<b>Non-Surgical Extractions</b>			
In Network	\$0	75%	25%
Out of Network	\$0	50%	50%

### VISION

Services	Medicare Pays	Plan G Plus Pays	You Pay
<b>Annual Routine Examination</b>			
In Network	\$0	100%	\$0
Out of Network	\$0	All except \$40	\$40
<b>Materials Allowance</b>			
In Network	\$0	\$130	Remaining Balance
Out of Network	\$0	\$65	Remaining Balance

### HEARING<sup>8</sup>

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

# Plan N

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

Services	Medicare Pays	Plan N Pays	You Pay
<b>Hospitalization<sup>4</sup></b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A deductible)	\$0
61st through 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$838 a day	\$838 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 <sup>5</sup>
Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care<sup>4</sup></b> 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 \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b> 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
<b>Medical Expenses — In or Out of the Hospital And Outpatient Hospital Treatment</b> , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$0	\$257 (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.
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$0	\$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services — Tests for Diagnostic Services</b>	100%	\$0	\$0

## MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan N Pays	You Pay
<b>Home Health Care Medicare-approved Services</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$0	\$257 (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
<b>Foreign Travel — Not Covered by Medicare</b> 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 N Plus

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

Services	Medicare Pays	Plan N Plus Pays	You Pay
<b>Hospitalization<sup>4</sup></b> Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A deductible)	\$0
61st through 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 Lifetime Reserve days	All but \$838 a day	\$838 a day	\$0
– Additional 365 days once Lifetime Reserve days are used	\$0	100% of Medicare-eligible expenses	\$0 <sup>5</sup>
Beyond the additional 365 days	\$0	\$0	All costs
<b>Skilled Nursing Facility Care<sup>4</sup></b> 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 \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>Hospice Care</b> 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 Plus

## MEDICARE (PART B) — MEDICAL SERVICES — PER CALENDAR YEAR

Services	Medicare Pays	Plan N Plus Pays	You Pay
<b>Medical Expenses — In or Out of the Hospital And Outpatient Hospital Treatment</b> , such as physicians' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$0	\$257 (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.
<b>Part B Excess Charges</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>Blood</b>			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$0	\$257 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
<b>Clinical Laboratory Services — Tests for Diagnostic Services</b>	100%	\$0	\$0

## MEDICARE (PARTS A & B)

Services	Medicare Pays	Plan N Plus Pays	You Pay
<b>Home Health Care Medicare-approved Services</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
– First \$257 of Medicare-approved amounts <sup>6</sup>	\$0	\$0	\$257 (Part B deductible)
– Remainder of Medicare-approved amounts	80%	20%	\$0

# Plan N Plus

## OTHER BENEFITS - NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan N Plus Pays	You Pay
<b>Foreign Travel — Not Covered by Medicare</b> 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 N Plus

## INNOVATIVE BENEFITS

### DENTAL

Services	Medicare Pays	Plan N Plus Pays	You Pay
<b>Diagnostic Evaluations</b>			
In Network	\$0	100%	\$0
Out of Network	\$0	50%	50%
<b>Preventive Services</b>			
In Network	\$0	100%	\$0
Out of Network	\$0	50%	50%
<b>Diagnostic Radiographs</b>			
In Network	\$0	100%	\$0
Out of Network	\$0	50%	50%
<b>Basic Restorative Services<sup>7</sup></b>	\$0	50%	50%
<b>Non-Surgical Extractions</b>			
In Network	\$0	75%	25%
Out of Network	\$0	50%	50%
<b>VISION</b>			
Services	Medicare Pays	Plan N Plus Pays	You Pay
<b>Annual Routine Examination</b>			
In Network	\$0	100%	\$0
Out of Network	\$0	All except \$40	\$40
<b>Materials Allowance</b>			
In Network	\$0	\$130	Remaining Balance
Out of Network	\$0	\$65	Remaining Balance
<b>HEARING<sup>8</sup></b>			
Services	Medicare Pays	Plan N Plus Pays	You Pay
<b>Annual Routine Examination</b>	\$0	100%	\$0
<b>Hardware Discounts</b>	\$0	Generally 30%	Remaining Balance

#### 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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