



2008 INDIVIDUAL PLAN OPTION CHANGE FORM

Please use this form to change from your current Blue MedicareRx prescription drug coverage option to a new coverage option (i.e., Standard to Value). Generally, you may only change your Blue MedicareRx prescription drug plan option during the annual coordinated election period (AEP), which is between November 15 and December 31 of each year, unless you qualify for a special enrollment period (SEP).

Before you complete the information on this form, please do the following:

- 1) Carefully review the Summary of Benefits (either enclosed with this form or via our web site at www.bcbsil.com) for the benefits and monthly premium that best meets your needs.
- 2) Get out your Blue MedicareRx ID card because you'll need it to fill out some of the information below.

Upon completing this form, mail the form to Blue MedicareRx in the enclosed postage-paid envelope. If one has not been provided to you, please refer to the last page of this form for the mailing address.

For more information about the enrollment periods, whether you qualify for an SEP or the benefits, please call our Customer Service Department at 1-888-285-2249, 8:00 a.m. - 8:00 p.m., local time, 7 days a week. For the hearing or speech impaired, please call 1-888-285-2252.

Remember: Complete this form only if you wish to change your current Blue MedicareRx prescription drug coverage option.

Member Name: _____

Member Number (Printed on your Blue MedicareRx ID card):

Medicare ID Number (Printed on your red, white, and blue Medicare ID card):

- -

In which enrollment period are you changing your plan option?

- AEP: Annual Election Period (November 15 - December 31)**
- Please complete Sections 1 and 3 only
 - Sign the form (see Section 3) and return it in the enclosed postage-paid envelope or to the address on the back of this form.
 - Effective date of change: January 1, 2008
- SEP: Special Election Period (See section 2 for qualifying events)**
- Please complete Sections 1, 2 and 3
 - Sign the form (see Section 3) and return it in the enclosed postage-paid envelope or to the address on the back of this form.
 - Effective date of change: Generally the first of the month following receipt of this form (i.e., if we receive the form on March 28, generally your effective date will be April 1)

SECTION 1

Please check the appropriate box, indicating which plan option you wish to change to:

Blue MedicareRx Standard Option **Monthly Premium - \$31.60**

Deductible — \$275

Copayments

- \$0 for Generic drugs
- \$35 for Preferred Brand drugs
- \$65 for Brand drugs
- 25% coinsurance for Specialty drugs

Coverage Gap — You pay 100% between \$2,510 – \$4,050 in total covered drug costs.

Catastrophic Coverage — After \$4,050 out-of-pocket, you pay the greater of:

- 5% coinsurance or
- \$2.25 for Generic / \$5.60 for other drugs

Blue MedicareRx Value Option **Monthly Premium - \$27.80**

Deductible — \$0

Copayments

- \$7 for Generic drugs
- \$45 for Preferred Brand drugs
- \$75 for Brand drugs
- 30% coinsurance for Specialty drugs

Coverage Gap — You pay 100% between \$2,510 – \$4,050 in total covered drug costs.

Catastrophic Coverage — After \$4,050 out-of-pocket, you pay the greater of:

- 5% coinsurance or
- \$2.25 for Generic / \$5.60 for other drugs

Blue MedicareRx Plus Option **Monthly Premium - \$70.10**

Deductible — \$0

Copayments

- \$5 for Generic drugs
- \$38 for Preferred Brand drugs
- \$60 for Brand drugs
- 30% coinsurance for Specialty drugs

Coverage Gap — You pay \$5 for Generic drugs and 100% for Preferred Brand, Brand and Specialty drugs between \$2,510 – \$4,050 in total covered drug costs.

Catastrophic Coverage — After \$4,050 out-of-pocket, you pay the greater of:

- 5% coinsurance or
- \$2.25 for Generic / \$5.60 for other drugs

SECTION 2

Information to Determine Enrollment Periods

Typically, you may only change your Medicare Prescription Drug Plan during the annual open enrollment period between November 15 and December 31 of each year. However, there are exceptions that may allow you to change Blue MedicareRx plans outside of the annual open enrollment period.

Please review the following statements, then check the box that applies to you. If additional information is necessary, Blue Cross and Blue Shield of Illinois will contact you.

- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I receive extra help or I am no longer eligible for extra help paying for Medicare prescription drug coverage.
- I live in or recently moved out of a Long Term Care Facility (for example, a nursing home or long term care facility)
- I belong to a pharmacy assistance program provided by my state.

To ensure timely processing of your enrollment and determine if your requested effective date can be accommodated, it is imperative we understand the date associated with the reason checked above. (e.g. date of move; date creditable coverage ends) / /

If none of these statements applies to you, or if you are not sure, please contact us to see if you are eligible to enroll.

SECTION 3

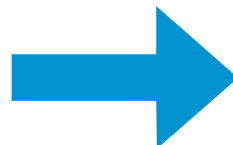
Please Read and Sign Below

I have reviewed the Summary of Benefits before completing this form. I want to change from my current Blue MedicareRx plan option to the plan option I have selected.

Signature: **X** _____ Today's Date: _____

Member Name: _____ Phone Number: _____

CONTINUE TO NEXT PAGE



If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: () – _____

Relationship to Enrollee: _____

Agent Information if Applicable: (Please Print)

Note: This section should identify the agent OR agency that is to be compensated for this applicant.

Agent OR Agency Name: _____

Agent Code (i.e., Tax ID#/SS#): _____

Signature of Agent: _____ Date Signed: _____

Phone Number: _____ Agency Name: (if applicable) _____

The person that is discussing plan options with you is either employed by or contracted with Blue MedicareRx. This person may be compensated based on your enrollment in Blue MedicareRx.

Please mail this completed form in the postage-paid envelope provided or to the address below.

Blue MedicareRx
P.O. Box 2190
Chester, VA 23831

SM Service Mark of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

® Registered Service Marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans

Blue Cross and Blue Shield of Illinois refers to HCSC Insurance Services Company, which is a wholly owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company. These companies are independent licensees of the Blue Cross and Blue Shield Association and offer or provide services for Medicare Part D products under contract number S5715 with the Centers for Medicare and Medicaid Services.