

Regence BlueCross BlueShield of Oregon—2011 Outline of Medicare Supplement (Medigap) Coverage

Companion Plan A, Plan C, Plan D, Plan E, Plan F, Plan F-High Deductible and Plan G

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan “A.” Some plans may not be available in our state. The plans offered by Regence BlueCross BlueShield of Oregon are shaded in the chart below and include Plans A, C, D, E, F, F-High Deductible and G. See Outlines of Coverage sections for details about all plans.

BASIC BENEFITS: For Plans A - J.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
 Medical Expenses: Part B coinsurance (generally 20% of the Medicare-approved expenses) or copayments for hospital outpatient services.
 Blood: First three pints of blood each year.

A	B	C	D	E	F*	G	H	I	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
	Part B Deductible	Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)	Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medicare

**Plans F and J also have an option called a high deductible plan F and a high deductible plan J. (Regence BlueCross BlueShield of Oregon offers Plan F-High Deductible but does not offer Plan J-High Deductible) These high deductible plans pay the same benefits as Plans F and J after one has paid a \$2,000 calendar year deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.*

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Regence BlueCross BlueShield of Oregon

Outline of Medicare Supplement (Medigap) Coverage – Page 2

Basic Benefits for Plans K and L include similar services as plans A-J (except they don't cover the first three pints of blood) but, cost sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits End 50% Other Part A Coinsurance, including Hospice 50% Part B Coinsurance 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits End 75% Other Part A Coinsurance, including Hospic 75% Part B Hospital Coinsurance 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	\$4,620 out-of-pocket annual limit***	\$2,310 out-of-pocket annual limit***

** Plans K and L provide for different cost-sharing for items and services than Plans A – J.

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.



Premium Information

Rates effective Jan. 1, 2011

Companion Plan	AGE				
	<70	70-74	75-79	80-84	85+
Plan A	\$170	\$183	\$220	\$230	\$240
Plan C	\$189	\$203	\$244	\$257	\$267
Plan D	\$173	\$189	\$225	\$237	\$248
Plan E	\$179	\$193	\$230	\$242	\$255
Plan F	\$192	\$208	\$248	\$263	\$275
Plan F-High Deductible	\$62	\$67	\$80	\$84	\$88
Plan G	\$174	\$189	\$226	\$238	\$249

You can choose one of these two payment methods (check which method you prefer on your application):

1. *Automatic Bank Withdrawal* – You can pay monthly by automatic withdrawal from your bank account. If you choose this method, follow the instructions on the application. We will send you a reminder before the first bank withdrawal is made.
2. *Direct Billing* – You can pay monthly or quarterly.

Regardless of which payment method you choose, SEND NO MONEY AT THIS TIME. We will bill you for the premium.

Premium Information

We, Regence BlueCross BlueShield of Oregon, can only raise your premium if we raise the premium for all policies like yours in this state.

General Information

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 health care service contractor.

Right To Return Policy

If you find that you are not satisfied with your policy, you may return it to PO Box 1271, Portland, Oregon 97207-1271. 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 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 Regence BlueCross BlueShield of Oregon nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult the "*Medicare and You*" booklet, produced by the federal government for more details: www.medicare.gov/spotlights.asp#medicare2008.

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.

Quick Reference Guide to This Outline

The description of each plan can be found on the page numbers indicated below.

Plan A	5-6
Plan C	7-9
Plan D	9-12
Plan E	12-15
Plan F	15-17
Plan F-High Deductible	18-20
Plan G	21-23

Plan A			
Services	Medicare Pays	Plan A Pays	You Pay
Medicare (Part A) – Hospital Services – Per Benefit Period			
Hospitalization*			
Semi-private room & board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,132	\$0	\$1,132 (Part A deductible)
61st thru 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care*			
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 thru 100th day	All but \$141.50 a day	\$0	Up to \$141.50 a day
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

* A benefit period begins on the first day you receive service 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.

** **Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 (continued)			
Services	Medicare Pays	Plan A Pays	You Pay
Medicare (Part B) – Medical Services – Per Calendar Year			
Medical Expenses—in or out of hospital and outpatient hospital treatment , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment.			
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	\$0	All costs
Blood			
First 3 pints	\$0	All costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services			
Blood tests for diagnostic services	100%	\$0	\$0
Medicare (Parts A & B)			
Home Health Care – Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Plan C			
Services	Medicare Pays	Plan C Pays	You Pay
Medicare (Part A) – Hospital Services – Per Benefit Period			
Hospitalization*			
Semi-private room & board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,132	\$1,132 (Part A deductible)	\$0
61st thru 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care*			
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 thru 100th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

* A benefit period begins on the first day you receive service 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.

** **Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 C (continued)			
Services	Medicare Pays	Plan C Pays	You Pay
Medicare (Part B) – Medical Services – Per Calendar Year			
Medical Expenses—in or out of hospital and outpatient hospital treatment , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment.			
First \$162 of Medicare-approved amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	\$0	All costs
Blood			
First 3 pints	\$0	All costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services			
Blood tests for diagnostic services	100%	\$0	\$0
Medicare (Parts A & B)			
Home Health Care – Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
First \$162 of Medicare-approved amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Plan C (continued)			
Services	Medicare Pays	Plan C Pays	You Pay
Other Benefits Not Covered by Medicare			
Foreign Travel			
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 lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
Plan D			
Services	Medicare Pays	Plan D Pays	You Pay
Medicare (Part A) – Hospital Services – Per Benefit Period			
Hospitalization*			
Semi-private room & board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,132	\$1,132 (Part A deductible)	\$0
61st thru 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs

* A benefit period begins on the first day you receive service 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.

** **Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 D (continued)			
Services	Medicare Pays	Plan D Pays	You Pay
Medicare (Part A) – Hospital Services – Per Benefit Period (continued)			
Skilled Nursing Facility Care* 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 thru 100th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance
Medicare (Part B) – Medical Services – Per Calendar Year			
Medical Expenses—in or out of hospital and outpatient hospital treatment , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment.			
First \$162 of Medicare-approved amounts**	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	\$0	All costs

* A benefit period begins on the first day you receive service 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.

** Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Plan D (continued)			
Services	Medicare Pays	Plan D Pays	You Pay
Medicare (Part B) – Medical Services – Per Calendar Year (continued)			
Blood			
First 3 pints	\$0	All Costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services			
Blood tests for diagnostic services	100%	\$0	\$0
Medicare (Parts A & B)			
Home Health Care – Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
At-Home Recovery Service – Not covered by Medicare			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare-approved a Home Care Treatment Plan.			
Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	Balance
Calendar year maximum	\$0	\$1,600	Balance

* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Plan D (continued)			
Services	Medicare Pays	Plan D Pays	You Pay
Other Benefits Not Covered by Medicare			
Foreign Travel			
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 lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
Plan E			
Services	Medicare Pays	Plan E Pays	You Pay
Medicare (Part A) – Hospital Services – Per Benefit Period			
Hospitalization*			
Semi-private room & board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,132	\$1,132 (Part A deductible)	\$0
61st thru 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs

* A benefit period begins on the first day you receive service 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.

** **Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 E (continued)			
Services	Medicare Pays	Plan E Pays	You Pay
Medicare (Part A) – Hospital Services – Per Benefit Period (continued)			
Skilled Nursing Facility Care*			
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 thru 100th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance
Medicare (Part B) – Medical Services – Per Calendar Year			
Medical Expenses—in or out of hospital and outpatient hospital treatment , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment.			
First \$162 of Medicare-approved amounts**	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	\$0	All costs

* A benefit period begins on the first day you receive service 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.

** Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Plan E (continued)			
Services	Medicare Pays	Plan E Pays	You Pay
Medicare (Part B) – Medical Services – Per Calendar Year (continued)			
Blood			
First 3 pints	\$0	All Costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services			
Blood tests for diagnostic services	100%	\$0	\$0
Medicare (Parts A & B)			
Home Health Care – Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Other Benefits Not Covered by Medicare			
Foreign Travel			
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 lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Plan E (continued)			
Services	Medicare Pays	Plan E Pays	You Pay
Other Benefits Not Covered by Medicare (continued)			
Preventive Medical Care Benefit***			
Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All costs
Plan F			
Services	Medicare Pays	Plan F Pays	You Pay
Medicare (Part A) – Hospital Services – Per Benefit Period			
Hospitalization*			
Semi-private room & board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,132	\$1,132 (Part A deductible)	\$0
61st thru 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs

* A benefit period begins on the first day you receive service 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.

** **Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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.

*** Medicare benefits are subject to change. Please consult the latest "Guide to Health Insurance for People with Medicare."

Plan F (continued)			
Services	Medicare Pays	Plan F Pays	You Pay
Medicare (Part A) – Hospital Services – Per Benefit Period (continued)			
Skilled Nursing Facility Care*			
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 thru 100th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance
Medicare (Part B) – Medical Services – Per Calendar Year			
Medical Expenses—in or out of hospital and outpatient hospital treatment , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment.			
First \$162 of Medicare-approved amounts**	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	100%	\$0

* A benefit period begins on the first day you receive service 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.

** Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Plan F (continued)			
Services	Medicare Pays	Plan F Pays	You Pay
Medicare (Part B) – Medical Services – Per Calendar Year (continued)			
Blood			
First 3 pints	\$0	All Costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services			
Blood tests for diagnostic services	100%	\$0	\$0
Medicare (Parts A & B)			
Home Health Care – Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
First \$162 of Medicare-approved amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
Other Benefits Not Covered by Medicare			
Foreign Travel			
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 lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Plan F – High Deductible

Services	Medicare Pays	After You Pay \$2,000 Deductible [▲] Plan F-High Deductible Pays	In Addition to \$2,000 Deductible [▲] You Pay
Medicare (Part A) – Hospital Services – Per Benefit Period			
Hospitalization*			
Semi-private room & board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,132	\$1,132 (Part A deductible)	\$0
61st thru 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care*			
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 thru 100th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

▲ *Plan F-High Deductible pays the same or offers the same benefits as Plan F, after one has paid a calendar year deductible \$2,000. Benefits from Plan F-High Deductible will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.*

* *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.*

** **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 F – High Deductible (continued)

Services	Medicare Pays	After You Pay \$2,000 Deductible [▲] Plan F-High Deductible Pays	In Addition to \$2,000 Deductible [▲] You Pay
Medicare (Part A) – Medical Services – Per Calendar Year			
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance
Medicare (Part B) – Medical Services – Per Calendar Year			
Medical Expenses—in or out of hospital and outpatient hospital treatment , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment.			
First \$162 of Medicare-approved amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	100%	\$0
Blood			
First 3 pints	\$0	All costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services			
Blood tests for diagnostic services	100%	\$0	\$0

▲ *Plan F-High Deductible pays the same or offers the same benefits as Plan F, after one has paid a calendar year deductible \$2,000. Benefits from Plan F-High Deductible will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.*

* *Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.*

Plan F – High Deductible (continued)

Services	Medicare Pays	After You Pay \$2,000 Deductible [▲] Plan F-High Deductible Pays	In Addition to \$2,000 Deductible [▲] You Pay
Medicare (Part A & B)			
Home Health Care – Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
First \$162 of Medicare-approved amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0
Other Benefits Not Covered by Medicare			
Foreign Travel			
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 lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

▲ Plan F-High Deductible pays the same or offers the same benefits as Plan F, after one has paid a calendar year deductible \$2,000. Benefits from Plan F-High Deductible will not begin until out-of-pocket expenses are \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Plan G			
Services	Medicare Pays	Plan G Pays	You Pay
Medicare (Part A) – Hospital Services – Per Benefit Period			
Hospitalization*			
Semi-private room & board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,132	\$1,132 (Part A deductible)	\$0
61st thru 90th day	All but \$283 a day	\$283 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care*			
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 thru 100th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

* A benefit period begins on the first day you receive service 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.

** **Notice:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 G (continued)			
Services	Medicare Pays	Plan G Pays	You Pay
Medicare (Part B) – Medical Services – Per Calendar Year			
Medical Expenses—in or out of hospital and outpatient hospital treatment , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment.			
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	80%	20%
Blood			
First 3 pints	\$0	All costs	\$0
Next \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
Clinical Laboratory Services			
Blood tests for diagnostic services	100%	\$0	\$0
Medicare (Parts A & B)			
Home Health Care – Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
First \$162 of Medicare-approved amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

* Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

Plan G (continued)

Services	Medicare Pays	Plan G Pays	You Pay
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Medicare (Parts A & B) (continued)

At-Home Recovery Service – Not covered by Medicare

Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan.

Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare approved visits, not to exceed 7 each week	Balance
Calendar year maximum	\$0	\$1,600	Balance

Other Benefits Not Covered by Medicare

Foreign Travel

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 lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum



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