Regence BlueCross BlueShield of Oregon – Clark County

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Outline of Medicare Supplement (Medigap) Coverage – Companion Plan A, Plan C and Plan F

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 your state. See Outlines of Coverage sections for details about all plans. **The plans offered by Regence BlueCross BlueShield of Oregon are shaded in the chart below**.

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
	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 Excess (100%)	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. These high deductible plans pay the same benefits as Plans F and J after one has paid a $1,900 calendar year deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed $1,900. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the contract. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible. Regence BlueCross BlueShield of Oregon does not offer the high-deductible Plan F or J.

00975 rep LIT 4928 1/08 1

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, but cost sharing for the basic benefits is at different levels.

J*	K**	L**
Basic Benefits Skilled Nursing Facility Coinsurance Part A Deductible Part B Deductible Part B Excess (100%) Foreign Travel Emergency At-Home Recovery Preventive Care NOT covered by Medicare	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare benefits end 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare benefits end 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% coinsurance for Part B Preventive Services
	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
	50% Part A Deductible	75% Part A Deductible
	$4,440 out-of-pocket annual limit***	$2,220 out-of-pocket annual limit***

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a $1,900 calendar year deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed $1,900. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the contract. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible. Regence BlueCross BlueShield of Oregon does not offer the high-deductible Plan F or J.

**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 January 1, 2008

Companion Plan A	Companion Plan C	Companion Plan F
$98	**$191**	**$193**

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 contracts.

Read Your Contract Very Carefully

This is only an outline describing your contract's most important features. The contract is your insurance contract. You must read the contract itself to understand all of the rights and duties of both you and your health care service contractor.

Right To Return Contract

If you find that you are not satisfied with your contract, you may return it to PO Box 1271, Portland, Oregon 97207-1271. If you send the contract back to us within 30 days after you receive it, we will treat the contract as if it had never been issued and return all of your payments.

Contract Replacement

If you are replacing another health insurance contract, do NOT cancel it until you have actually received your new contract and are sure you want to keep it.

Notice

This contract 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 *Medicare and You* for more details.

Complete Answers Are Very Important

When you fill out the application for the new contract, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your contract 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			
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 $1,024	$0	$1,024 (Part A deductible)
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $512 a day	$512 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 $128 a day	$0	Up to $128 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 contract'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 $135 of Medicare approved amounts*	$0	$0	$135 (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 $135 of Medicare approved amounts*	$0	$0	$135 (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 $135 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 80%	 $0 20%	 $135 (Part B deductible) $0

Once you have been billed $135 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 $1,024	$1,024 (Part A deductible)	$0
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after: While using 60 lifetime reserve days Once lifetime reserve days are used: Additional 365 days Beyond the additional 365 days	All but $512 a day $0 $0	$512 a day 100% of Medicare eligible expenses $0	$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 $128 a day	Up to $128 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 contract'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 $135 of Medicare approved amounts*	$0	$135 (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 $135 of Medicare approved amounts*	$0	$135 (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 $135 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 80%	 $135 (Part B deductible) 20%	 $0 $0

* *Once you have been billed $135 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—not covered by Medicare 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

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 $1,024	$1,024 (Part A deductible)	$0
61st thru 90th day	All but $256 a day	$256/day	$0
91st day and after: While using 60 lifetime reserve days	All but $512 a day	$512 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 contract'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 (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 $128 a day	Up to $128 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 $135 of Medicare approved amounts**	$0	$135 (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 $135 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) (continued)			
Blood			
First 3 pints	$0	All costs	$0
Next $135 of Medicare-approved amounts*	$0	$135 (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 $135 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 80%	 $135 (Part B deductible) 20%	 $0 $0

* *Once you have been billed $135 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**
Other Benefits – not covered by Medicare			
Foreign Travel—not covered by Medicare 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