

Regence Bridge Medigap (Medicare Supplement) Plans

Making sure you have the coverage that's right for you.

Regence
Medicare Plans





Table of contents

Cover letter

Regence Bridge Medigap Information Section (Overview)

This section provides you with basic information about Medicare, Medigap benefits, critical issues to consider when selecting a Medigap plan, when and how to enroll, and where to get the answers to your questions.

Outline of Coverage Section (Detail)

The Outline of Coverage digs deeper into the details of each plan, what the plan pays and what Medicare pays, and what the monthly rate is. This section should give you the detail you need to decide which plan you want.

Helping your Medicare coverage do more

Thank you for inquiring about Regence BlueCross BlueShield of Oregon's Medigap (Medicare Supplement) plans.

Many people with Original Medicare Parts A and B find that they want coverage for some of the things that aren't covered by Medicare, such as deductibles and coinsurance. Medigap plans were designed for just that purpose – to supplement Medicare coverage, providing you with a more complete health care package.

This booklet explains the benefits of Medigap plans, and more specifically, the benefits of Regence Bridge Medigap Plans. Because we offer a wide range of coverage options, we are confident you'll find a plan that suits both your health and financial needs.

You'll also find information on additional programs Regence makes available to its members. Your good health is important to us. That's why we offer programs and tools to help you better understand your health needs, prescriptions and wellness options. For example, take a look at **myRegence.com**. On this secure, members-only website, you can see your claims history, search for providers, store your personal health records and learn about health conditions and prescription drugs. Access to this site comes with your Regence membership.

In addition, our Regence Advantages program offers you savings from a number of nationally recognized, health-related companies. Discounts are available for a variety of programs, from local gyms to weight loss programs, and from hearing aids to LASIK eye surgery. **THESE PROGRAMS ARE NOT INSURANCE BUT ARE OFFERED IN ADDITION TO YOUR MEDIGAP PLAN TO HELP YOU GET INFORMATION AND SUPPORT WHEN YOU NEED IT. WE RESERVE THE RIGHT TO CHANGE THESE SERVICES AT ANY TIME.**

Applying is easy. Simply complete and return the enclosed application in the return envelope provided. You can also contact us or your insurance producer (agent) for more information. To contact us by phone call 1-888-REGENCE (1-888-734-3623). TTY users should call 711. Or, you can visit our website at **www.regence.com/medicare**.

We hope you'll discover why so many Medicare beneficiaries in Oregon rely on Regence BlueCross BlueShield of Oregon for their health care coverage.

Sincerely,



Jim Walton
Director, Sales

Regence BlueCross BlueShield of Oregon
P.O. Box 1271, Portland, OR 97207-1271



Regence Bridge Medigap Plans

Overview

This section provides you with basic information about Medicare, Medigap benefits, critical issues to consider when selecting a Medigap plan, when and how to enroll, and where to get the answers to your questions.

Table of contents

Medicare basics	3
How to get more information about Medicare and Medigap ...	5
Choosing a Medigap plan that's right for you	6
Regence Bridge Medigap options	7
What does each Medigap benefit cover?	8
Tools to help you make the most of your health.	10
How do I apply?	11
Frequently asked questions.	13
Glossary	15
Exclusions	17

Medicare basics

To make the right choice for you, start with some simple facts about Medicare.

- You become eligible for Medicare either by “aging in” (turning 65) or qualifying as disabled.
- When you become eligible for Medicare, you have a seven-month window to enroll (the month of your eligibility, the three months before and the three months after). After this, there are set enrollment periods when you can enroll late or switch plans.
- At the time of Medicare eligibility, most people automatically receive Medicare Part A, which is for hospital care.
- You can add Part B, which covers doctor visits. Part B premiums typically come out of your monthly Social Security payment. With Part B, you also pay deductibles and coinsurance.
- Part D covers prescription drugs. It’s optional and is provided by private health coverage carriers.
- Parts A and B don’t necessarily cover all your medical expenses.

To cover some of the services that Parts A and B don’t, you can get additional coverage, such as a **Medigap** plan, to help you with Parts A and B deductibles and coinsurance and some expenses Parts A and B don’t cover. The federal government has standardized Medigap plans, which means that each standardized plan must offer the same basic benefits, no matter which insurance company sells it. You’ll see differences only in the carriers’ customer service, stability, and extra programs and services. No matter which carrier you choose, you can see any provider who accepts Medicare.

Medigap plans don’t offer prescription drug coverage. If you want prescription drug coverage in addition to your Medigap coverage, you’ll need to also purchase a Part D Medicare Prescription Drug Plan offered by a private carrier.

If you’re considering changing plans and need more information, call us at 1-888-REGENCE (1-888-734-3623); callers with hearing impairment can call TTY 711. Hours for both numbers are Monday through Friday between 8 a.m. and 5 p.m. Pacific time. You can also call your insurance producer (agent).

When is the best time to enroll in a Medigap plan?

The best time is during your Medigap open enrollment period. This is the six-month period that begins on the first day of the month in which you are age 65 or older and enrolled in Medicare Part B. During this time you are guaranteed the right to buy any Medigap policy sold by any carrier doing Medigap business in your state without submitting a health statement.

Other enrollment situations

There are other situations outside your Medigap open enrollment period when you may be eligible to apply for a Medigap plan. In most cases these are when you lose or drop other health care coverage. A few of the situations are listed in the table below. Call us at 1-888-REGENCE (1-888-734-3623) TTY: 711 Monday through Friday between 8 a.m. and 5 p.m. Pacific time for more information on eligibility periods.

For more information about Medigap policies, visit www.medicare.gov to view a copy of “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.” Under Search Tools, select *Find a Medicare Publication*.

Eligibility situation	Regence Bridge Medigap options	Timing
You're on a Medicare Advantage plan, but your carrier is leaving Medicare or no longer provides coverage in your area, or you move out of the carrier's service area.	You can buy Regence Bridge Medigap Plan A, C, F or K. You'll need to switch to Original Medicare rather than joining another Medicare Advantage plan.	You can apply up to 60 calendar days before the date your health care coverage will end. You must apply no later than 63 days after your health care coverage ends.
You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays, and that coverage is ending.	You can buy Regence Bridge Medigap Plan A, C, F or K. If you have COBRA coverage, you can either buy a Medigap policy right away or wait until your COBRA coverage ends.	You must apply no later than 63 calendar days after the latest of these three dates: <ol style="list-style-type: none"> 1. Date the coverage ends 2. Date on the notice you get telling you that coverage is ending (if you get one) 3. Date on a claim denial, if this is the only way you know that your coverage ended
You joined a Medicare Advantage plan when you were first eligible for Medicare Part A at age 65, and within the first year of joining you decide you want to switch to Original Medicare.	You may buy Regence Bridge Medigap Plan A, C, F or K.	You can apply up to 60 calendar days before the date your coverage will end. You must apply no later than 63 days after your coverage ends.
You dropped a Medigap policy to join a Medicare Advantage plan for the first time; you have been on the plan less than a year and now want to switch back.	You may buy the Regence Medigap policy you had previously if it's still available. If your former Medigap policy isn't available, you can buy Regence Bridge Medigap Plan A, C, F or K.	You can apply up to 60 calendar days before the date your coverage will end. You must apply no later than 63 days after your coverage ends.

How to get more information about Medicare and Medigap

Regence

Call us weekdays, between 8 a.m. and 5 p.m. Pacific time:

Toll-free: 1-888-REGENCE (1-888-734-3623)

TTY: 711

We also have product details and forms for all our Regence Bridge Medigap plans online at www.regence.com/medicare.

Medicare

You can reach Medicare representatives 24 hours a day, seven days a week at the Medicare hotline:

Toll-free: 1-800-MEDICARE (1-800-633-4227)

TTY/TDD users should call 1 (877) 486-2048

Online resources are also available for general Medicare info:

www.medicare.gov

You can also call an insurance producer (agent).

Choosing a Medigap plan that's right for you

When it comes to choosing a Medigap plan, there's a lot to think about.

That's why we're committed to helping you through the entire process. We'll help you identify your needs, review your options and answer your questions while you fill out your paperwork. Then, when you become a member, we're here to answer your claims questions, help you find a doctor and give you the information you need to make the health care decisions that are right for you.

Coverage you need without networks or hassles: We're here to help make it easy.

To see which plan will fit you best, first determine what you need.

Do you have a chronic condition that requires frequent doctor visits? If so, **Plan F** might be a good choice for you, as it covers both the Part B deductible and excess charges.

If you rarely need care, **Plan A** might be all you need. Or, you might want to take a look at **Plan K**, which has a lower premium but greater cost-sharing.

If you travel outside the United States on a regular basis, **Plans C** and **F** cover foreign travel emergencies.

As you think about what plan to choose, take a look at your past medical bills to see what kind of costs you might have in the future. Or, give one of our Medigap sales representatives a call. You can also call your insurance producer (agent.)

With **all** our Medigap plans, you have total control over your choice of providers. There are no network restrictions or referrals needed, so you can see any provider who accepts Medicare coverage.

Regence Bridge Medigap options

Regence offers Medigap Plans A, C, F and K. All Medigap plans offer the same “basic benefits”: Medicare Part A coinsurance and all costs after hospital benefits are exhausted; Medicare Part B coinsurance/copays; the first three pints of blood; and hospice care coinsurance/copays.

In a sense, the basic benefits cover the “big ticket items”—the health care costs that are most likely to escalate and put your finances in jeopardy. These benefits are in addition to what Medicare Parts A and B cover and are meant to **supplement** Medicare coverage, providing you with a more complete health care package.

If you want more coverage than the basic benefits, all of the plans except Plan A have additional benefits. You choose the combination of benefits that best meets your needs.

The chart below gives you a quick look at the plans and benefits. X’s indicate the benefit is provided in that plan. Please note that Plan K covers many benefits at 50% and also has an out-of-pocket annual limit. Immediately following the chart is an explanation of the benefits.

Basic (core) benefits	Regence Bridge Plan A	Regence Bridge Plan C	Regence Bridge Plan F	Regence Bridge Plan K
Medicare Part A coinsurance and all costs after hospital benefits are exhausted	✓	✓	✓	✓
Medicare Part B coinsurance/copays	✓	✓	✓	50%
Blood - first 3 pints	✓	✓	✓	50%
Hospice care coinsurance/copays	✓	✓	✓	50%
Additional benefits				
Skilled nursing facility coinsurance		✓	✓	50%
Part A deductible		✓	✓	50%
Part B deductible		✓	✓	
Part B excess charges			✓	
Foreign travel emergency		80%	80%	
Out-of-pocket annual limit				\$4,660

What does each Medigap benefit cover?

Basic benefits – offered in all plans

Medicare Part A coinsurance

This is the percentage of the Medicare-approved amount you may have to pay after you meet the Part A deductible.

Medicare Part B coinsurance

This is the percentage of the Medicare-approved amount you may have to pay after you meet the Part B deductible.

Blood – first 3 pints each year

Hospice care coinsurance/copays

You must meet Medicare's requirements for hospice, including a doctor's certificate of terminal illness.

Additional benefits – offered by some plans

Skilled nursing facility coinsurance (Plans C, F, K*)

You share a portion of skilled nursing facility expenses with Medicare. Your share of the cost is called your "coinsurance". The skilled nursing facility benefit is for special, short-term treatment or care after you've been in the hospital. This is not the same as routine nursing home care. No Medigap plan pays for nursing home or long-term care.

Medicare Part A deductible (Plans C, F, K*)

When hospitalized, you're required to pay a Medicare Part A deductible before Medicare begins to pay for any covered services. The deductible is required once per benefit period. A benefit period begins the day you go to a hospital or skilled nursing facility. It ends when you haven't received any inpatient hospital care (or care in a skilled nursing facility) for 60 days in a row. If you go into a hospital or a skilled nursing facility after a benefit period has ended, a new benefit period begins and you'll have to pay a new deductible.

**PLEASE NOTE: Plan K covers 50% of the charges and you cover 50%.*

Medicare Part B deductible (Plans C, F)

Medicare Part B pays for many physician services and other medical care. However, before Medicare begins to pay for services each year, you have to pay a Medicare Part B deductible.

Medicare Part B excess charges (Plan F)

Sometimes you may receive Medicare Part B services from a doctor or provider who does not accept Medicare Assignment. This means the doctor may charge more for medical services than Medicare will pay. This extra amount is called “excess charges.” Plan F covers 100% of Part B excess charges.

Foreign travel emergency (Plans C, F)

In most cases, Medicare doesn't pay for care provided outside the United States. During a trip to a foreign country, you may need emergency hospital, physician or medical care. If you receive medically necessary emergency care for an illness or injury that begins during the first 60 days of a trip and your care isn't covered by Medicare, then you pay the first \$250 (once every calendar year) for Medicare-eligible expenses. Once you've paid this amount, your Medigap plan pays 80% of the billed charges for Medicare-eligible expenses up to a lifetime maximum of \$50,000.

This brochure provides a brief summary of plans. You'll find more detailed information in the “Outline of Medicare Supplement Coverage.” Only the policy contains a complete description of the coverage.

Tools that help you make the most of your health

We provide more than benefits. We also provide ways to help you stay healthy and better manage your health care costs, including online tools and information and value-added services such as fitness program discounts.

Manage your health at myRegence.com

Your good health is important to us. That's why we offer programs and tools to help you better understand your health needs, prescriptions and wellness options.

For example, take a look at myRegence.com. On this secure, members-only website, you can see your claims history, search for providers, store your health personal records and learn about health conditions and prescription drugs. Access to this site comes with your Regence membership.

Regence Advantages program offers discounts

Our Regence Advantages program offers you savings from a number of nationally recognized, health-related companies. Just have your member card ready at the time of service. Discounts include a variety of programs, from local gyms to weight loss programs, and from hearing aids to LASIK eye surgery. **THESE PROGRAMS ARE NOT INSURANCE BUT ARE OFFERED IN ADDITION TO YOUR MEDIGAP PLAN TO HELP YOU GET INFORMATION AND SUPPORT WHEN YOU NEED IT. WE RESERVE THE RIGHT TO CHANGE THESE SERVICES AT ANY TIME.**

How do I apply?

If you're undecided about which plan you want

If you need help deciding which plan will work the best for you, please let us know. As you read through this packet of information we've sent you, please don't hesitate to call us at the number below to get answers to your questions. Or, at your request, we'll send one of our Medigap sales representatives to your home to walk you through your options.

To get information or schedule a home visit, give us a call at 1-888-REGENCE (1-888-734-3623), talk to an insurance producer (agent), or visit www.regence.com/medicare.

If you're ready to enroll, here's what you need to do:

1) Determine if you're eligible to apply.

You may apply for a Regence Bridge Medigap plan if you:

- Reside in Oregon
- Are enrolled, or will be enrolled, in Medicare Parts A and B at the time of coverage

2) Determine when you can apply.

Check the eligibility and enrollment information on page 3.

3) Apply.

Medicare paperwork can be daunting. That's why we've worked to make it as easy as possible to apply for one of our Regence Bridge Medigap plans. There are three different ways to submit an application:

1. Fill out the application enclosed in the packet. Follow the instructions on the application. Be sure to complete in ink all the parts that pertain to you, and then sign and mail. A return envelope is enclosed.
2. Apply online at www.regence.com/medicare.
3. Contact your insurance producer (agent).

4) Payment options

When completing your application, select one of the two payment options on the application form:

1. Direct bill: We can send a direct billing statement to the home address you provide on your application. Be sure to check whether you want the bill monthly, quarterly, semi-annually or annually.
2. Surepay: Surepay allows you to have your premium withdrawn automatically each month from your personal checking or savings account. Payments are made monthly. By using Surepay you'll save on postage and on the time and expense of writing checks. You won't need to send in your first month's premium. We will automatically deduct it from your checking or savings account. A Surepay form is enclosed for your convenience.

Frequently asked questions

Who is eligible to apply?

Anyone with Medicare Parts A and B who lives in Oregon may apply.

When will my coverage be effective?

Subject to you meeting the eligibility requirements, coverage will begin on the first day of the month following our acceptance of the application.

How do I begin to receive care under this plan?

Simply show your member card to your health care providers so they know who to bill. That's it! In most cases, there's virtually no paperwork. You'll receive a new-member welcome packet. You can also give us a call if you have any questions. You'll find our contact information on page 4 and in your member materials.

Do you have any programs to help me maintain or improve my health?

Regence has a number of program options that help promote healthy living. For example, the CareEnhance® Nurse Advice Line is available anytime, 24 hours a day, seven days a week. If you have a question, don't know how to treat a health condition or are unsure about what kind of care you need, a free call to a registered nurse can get you back on track. These additional services are a complement to your policy, but are not insurance.

You also have access to our members-only Web site, **myRegence.com**, which provides a number of valuable health and wellness tools and resources.

What happens if I'm traveling and am outside the service area?

No matter where you are in the United States when you need care for an illness or injury, you have the choice of any licensed physician, provider or medical facility approved by Medicare.

In most cases, Medicare doesn't pay for care provided **outside** the United States. During a trip to a foreign country, you may need emergency hospital, physician or medical care. Regence Bridge Medigap Plans C and F help you with these expenses. With these plans, if you receive medically necessary emergency care for an illness or injury that begins during the first 60 days of a trip and your care isn't covered by Medicare, you pay the first \$250 for Medicare-eligible expenses each calendar year. Once you have paid this amount, we pay 80% of the billed charges for Medicare-eligible expenses up to a lifetime maximum of \$50,000.

Does it cost more to buy coverage through an insurance producer (agent)?

No. There's never an extra cost or obligation if you use an appointed insurance producer (agent). Insurance producers (agents) who are appointed to represent Regence provide a valuable service to clients and often can help you decide which of our Medicare plans is best for you.

Are prescription drugs covered?

No. Only Medicare Part B drugs are covered. You may be able to enroll in a Medicare Part D plan that will give you prescription drug coverage. Please contact a Regence Medigap sales representative at 1-888-REGENCE (1-888-734-3623) (TTY: 711) Monday through Friday, 8 a.m. to 5 p.m. Pacific time for more information.

How are eye exams covered?

Medicare provides coverage for diagnosis and treatment of eye conditions. Additionally, members with diabetes are eligible for a dilated eye exam once every calendar year. Routine medical eye exams are not a benefit of Medigap plans.

What can I do if I have a grievance or appeal?

If you aren't completely satisfied with our service or the quality of the medical care you received, please call Customer Service at 1 (888) 319-0942. Our goal is always to protect your rights and find a solution as quickly as possible.

On what basis could my Regence Medigap coverage be cancelled?

Here are some circumstances when your coverage could be cancelled:

- If you don't retain Medicare Parts A and B
- If you fail to pay the monthly premium, subject to a 30-day grace period
- If you commit fraud or allow another person to use your member card to obtain services
- If you commit fraud or make misrepresentations on your individual application form that affect your eligibility to enroll in this plan

Is there a waiting period before pre-existing conditions are covered?

No.

Glossary

Benefit period

Original Medicare uses benefit periods to measure your use of hospital and skilled nursing facility services. A benefit period begins the day you go into a hospital or skilled nursing facility. It ends when you haven't received either kind of care for 60 days in a row. If you go into a hospital or a skilled nursing facility after a benefit period has ended, a new one begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have, although inpatient mental health care in a psychiatric hospital is limited to 190 days in a lifetime.

Coinsurance

This is an amount you may be required to pay for services after you pay any plan deductibles. With Original Medicare, this is a percentage (such as 20%) of the Medicare-approved amount. You have to pay this amount after you pay the Part A and/or Part B deductible.

Copay

This is an amount that some Medicare health plans require you to pay for each medical service, such as a doctor's visit or prescription. It is usually a set amount. For example, you could pay \$10 or \$20 for a doctor's visit.

Deductible

This is the amount you must pay for health care before Original Medicare or other coverage begins to pay. For example, with Medicare Part A you pay a new deductible for each benefit period; with Medicare Part B you pay your deductible each year. These amounts can change every year.

Excess charges

If you are on Original Medicare, this is the difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

Lifetime reserve days

Under Original Medicare, these are additional days that Medicare will cover when you're in a hospital for more than 90 days. You have a total of 60 reserve days that you can use during your lifetime during hospital stays of more than 90 days. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Medicare-approved amount

Under Original Medicare, this is the amount paid to a doctor or supplier that accepts assignment. It includes what Medicare pays and any deductible, coinsurance or copay that you pay. It may be less than the actual amount a doctor or supplier charges.

Open enrollment period (Medigap)

This is a one-time-only, six-month period when federal law allows you to buy any Medigap policy you want that is sold in your state. It starts in the first month that you're covered under Medicare Part B and you are age 65 or older. During this period, you can't be denied a Medigap policy or charged more due to past or present health problems. Some states may have additional open enrollment rights under state law.

Original Medicare plan

Original Medicare has two parts: Part A (hospital coverage) and Part B (medical coverage). It is a fee-for-service health plan. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Premium

The periodic payment you make to Medicare, a private carrier or a health care plan for health care or prescription drug coverage.

Exclusions

We will not provide benefits for any of the following:

- Expenses duplicated by Medicare
- Expenses not covered by Medicare
- Services and supplies provided by a provider not recognized by Medicare—any services or supplies provided by a physician, hospital, skilled nursing facility, or any other provider that is not recognized as payable under the Medicare Act, except as specifically covered under the policy for foreign travel. This includes services provided by a provider who has opted out of Medicare, and who must by federal law, enter into an agreement with you regarding your liability for the care that provider gives you.
- Third party liability—services and supplies for treatment of illness or injury for which a third party is or may be responsible.

Medicare Supplement Plans (Medigap Plans)

Outline of Coverage



Regence BlueCross BlueShield of Oregon

Benefit Chart of Medicare Supplement Plans sold on or after June 1, 2010

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 in our state. The plans offered by Regence BlueCross BlueShield of Oregon are shaded in the chart below. See Outlines of Coverage sections for details about all plans. Plans E, H, I and J are no longer available for sale.

- BASIC BENEFITS:**
- 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. Plans K, L, and N require insured to pay a portion of Part B coinsurance or copayments
 - Blood:** First three pints of blood each year
 - Hospice:** Part A coinsurance

A	B	C	D	F/F*	G
Basic, including 100% Part B 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 B Deductible		Part B Deductible	
				Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

*Plan F also has an option called a high deductible plan F. The high deductible plan pays the same benefits as Plan F after one has paid a \$2,070 calendar-year deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2,070. 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.

Regence BlueCross BlueShield of Oregon

Outline of Medicare Supplement (Medigap) Coverage – Page 2

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit \$4,660; paid at 100% after limit reached	Out-of-pocket limit \$2,330; paid at 100% after limit reached		

Table of Contents

- Premium Information** 4

- Disclosures** 6

- Plan Descriptions**
- Plan A7
- Plan C 9
- Plan F..... 11
- Plan K14

Premium Information

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

Rates effective Jan. 1, 2012

Monthly Surepay Bill											
Age	<65	65	66	67	68	69	70	71	72	73	74
Plan A	\$117	\$117	\$121	\$127	\$132	\$137	\$143	\$148	\$152	\$155	\$161
Plan C	\$143	\$143	\$150	\$159	\$166	\$173	\$181	\$189	\$197	\$202	\$210
Plan F	\$144	\$144	\$151	\$160	\$167	\$174	\$183	\$190	\$198	\$203	\$211
Plan K	\$78	\$78	\$81	\$86	\$90	\$95	\$98	\$102	\$106	\$111	\$114
Monthly Paper Bill											
Age	<65	65	66	67	68	69	70	71	72	73	74
Plan A	\$119	\$119	\$123	\$129	\$134	\$139	\$145	\$150	\$154	\$157	\$163
Plan C	\$145	\$145	\$152	\$161	\$168	\$175	\$183	\$191	\$199	\$204	\$212
Plan F	\$146	\$146	\$153	\$162	\$169	\$176	\$185	\$192	\$200	\$205	\$213
Plan K	\$80	\$80	\$83	\$88	\$92	\$97	\$100	\$104	\$108	\$113	\$116
Quarterly Bill											
Age	<65	65	66	67	68	69	70	71	72	73	74
Plan A	\$353	\$353	\$365	\$383	\$398	\$413	\$431	\$446	\$458	\$467	\$485
Plan C	\$431	\$431	\$452	\$479	\$500	\$521	\$545	\$569	\$593	\$608	\$632
Plan F	\$434	\$434	\$455	\$482	\$503	\$524	\$551	\$572	\$596	\$611	\$635
Plan K	\$236	\$236	\$245	\$260	\$272	\$287	\$296	\$308	\$320	\$335	\$344
Semi-Annual Bill											
Age	<65	65	66	67	68	69	70	71	72	73	74
Plan A	\$704	\$704	\$728	\$764	\$794	\$824	\$860	\$890	\$914	\$932	\$968
Plan C	\$860	\$860	\$902	\$956	\$998	\$1,040	\$1,088	\$1,136	\$1,184	\$1,214	\$1,262
Plan F	\$866	\$866	\$908	\$962	\$1,004	\$1,046	\$1,100	\$1,142	\$1,190	\$1,220	\$1,268
Plan K	\$470	\$470	\$488	\$518	\$542	\$572	\$590	\$614	\$638	\$668	\$686
Annual Bill											
Age	<65	65	66	67	68	69	70	71	72	73	74
Plan A	\$1,406	\$1,406	\$1,454	\$1,526	\$1,586	\$1,646	\$1,718	\$1,778	\$1,826	\$1,862	\$1,934
Plan C	\$1,718	\$1,718	\$1,802	\$1,910	\$1,994	\$2,078	\$2,174	\$2,270	\$2,366	\$2,426	\$2,522
Plan F	\$1,730	\$1,730	\$1,814	\$1,922	\$2,006	\$2,090	\$2,198	\$2,282	\$2,378	\$2,438	\$2,534
Plan K	\$938	\$938	\$974	\$1,034	\$1,082	\$1,142	\$1,178	\$1,226	\$1,274	\$1,334	\$1,370

— Medicare Supplement Plans

Monthly Surepay Bill

Age	75	76	77	78	79	80	81	82	83	84	85+
Plan A	\$164	\$167	\$170	\$171	\$172	\$173	\$174	\$176	\$176	\$176	\$176
Plan C	\$216	\$222	\$229	\$234	\$238	\$243	\$247	\$251	\$255	\$260	\$263
Plan F	\$217	\$223	\$231	\$235	\$239	\$244	\$248	\$252	\$256	\$261	\$264
Plan K	\$117	\$120	\$123	\$127	\$129	\$131	\$134	\$136	\$138	\$140	\$143

Monthly Paper Bill

Age	75	76	77	78	79	80	81	82	83	84	85+
Plan A	\$166	\$169	\$172	\$173	\$174	\$175	\$176	\$178	\$178	\$178	\$178
Plan C	\$218	\$224	\$231	\$236	\$240	\$245	\$249	\$253	\$257	\$262	\$265
Plan F	\$219	\$225	\$233	\$237	\$241	\$246	\$250	\$254	\$258	\$263	\$266
Plan K	\$119	\$122	\$125	\$129	\$131	\$133	\$136	\$138	\$140	\$142	\$145

Quarterly Rate

Age	75	76	77	78	79	80	81	82	83	84	85+
Plan A	\$494	\$503	\$512	\$515	\$518	\$521	\$524	\$530	\$530	\$530	\$530
Plan C	\$650	\$668	\$689	\$704	\$716	\$731	\$743	\$755	\$767	\$782	\$791
Plan F	\$653	\$671	\$695	\$707	\$719	\$734	\$746	\$758	\$770	\$785	\$794
Plan K	\$353	\$362	\$371	\$383	\$389	\$395	\$404	\$410	\$416	\$422	\$431

Semi-Annual Rate

Age	75	76	77	78	79	80	81	82	83	84	85+
Plan A	\$986	\$1,004	\$1,022	\$1,028	\$1,034	\$1,040	\$1,046	\$1,058	\$1,058	\$1,058	\$1,058
Plan C	\$1,298	\$1,334	\$1,376	\$1,406	\$1,430	\$1,460	\$1,484	\$1,508	\$1,532	\$1,562	\$1,580
Plan F	\$1,304	\$1,340	\$1,388	\$1,412	\$1,436	\$1,466	\$1,490	\$1,514	\$1,538	\$1,568	\$1,586
Plan K	\$704	\$722	\$740	\$764	\$776	\$788	\$806	\$818	\$830	\$842	\$860

Annual Rate

Age	75	76	77	78	79	80	81	82	83	84	85+
Plan A	\$1,970	\$2,006	\$2,042	\$2,054	\$2,066	\$2,078	\$2,090	\$2,114	\$2,114	\$2,114	\$2,114
Plan C	\$2,594	\$2,666	\$2,750	\$2,810	\$2,858	\$2,918	\$2,966	\$3,014	\$3,062	\$3,122	\$3,158
Plan F	\$2,606	\$2,678	\$2,774	\$2,822	\$2,870	\$2,930	\$2,978	\$3,026	\$3,074	\$3,134	\$3,170
Plan K	\$1,406	\$1,442	\$1,478	\$1,526	\$1,550	\$1,574	\$1,610	\$1,634	\$1,658	\$1,682	\$1,718

Disclosures

Use this outline to compare benefits and premiums among policies. **This outline shows benefits and premium of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I and J are no longer available for sale.**

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 policy

If you find that you are not satisfied with your policy, you may return it to Regence BlueCross BlueShield of Oregon, P.O. 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. 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. Neither Regence BlueCross BlueShield of Oregon nor its agents are connected with Medicare.

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

*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.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization*			
Semi-private room & board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,156	\$0	\$1,156 (Part A deductible)
61st thru 90th day	All but \$289 a day	\$289 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$578 a day	\$578 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 \$144.50 a day	\$0	Up to \$144.50 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

You must meet Medicare's requirements including a doctor's certification of terminal illness.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0
--	---	------------------------------------	-----

****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)

Medicare (Part B) – Medical Services – Per Calendar Year

*Once you have been billed \$140 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.

Services	Medicare Pays	Plan Pays	You Pay
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 \$140 of Medicare Approved Amounts*	\$0	\$0	\$140 (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 \$140 of Medicare Approved Amounts*	\$0	\$0	\$140 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	\$0	\$0
Home Health Care – Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
First \$140 of Medicare Approved Amounts*	\$0	\$0	\$140 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

Plan C

Medicare (Part A) – Hospital Services – Per Benefit Period

*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.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization*			
Semi-private room & board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,156	\$1,156 (Part A deductible)	\$0
61st thru 90th day	All but \$289 a day	\$289 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$578 a day	\$578 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 \$144.50 a day	Up to \$144.50 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

You must meet Medicare's requirements including a doctor's certification of terminal illness.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0
--	---	------------------------------------	-----

****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)

Medicare (Part B) – Medical Services – Per Calendar Year

*Once you have been billed \$140 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.

Services	Medicare Pays	Plan Pays	You Pay
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 \$140 of Medicare Approved Amounts*	\$0	\$140 (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 \$140 of Medicare Approved Amounts*	\$0	\$140 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	\$0	\$0
Parts A & B			
Home Health Care – Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
First \$140 of Medicare Approved Amounts*	\$0	\$140 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

Plan C (continued)

Other Benefits – not covered by Medicare

Services	Medicare Pays	Plan Pays	You Pay
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

Medicare (Part A) – Hospital Services – Per Benefit Period

*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.

Services	Medicare Pays	Plan Pays	You Pay
Hospitalization*			
Semi-private room & board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,156	\$1,156 (Part A deductible)	\$0
61st thru 90th day	All but \$289 a day	\$289 a day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$578 a day	\$578 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

****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 F (continued)

Medicare (Part A) – Hospital Services – Per Benefit Period (continued)

*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.

Services	Medicare Pays	Plan Pays	You Pay
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 \$144.50 a day	Up to \$144.50 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

You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0
--	--	--------------------------------	-----

Medicare (Part B) – Medical Services – Per Calendar Year

**Once you have been billed \$140 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.

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 \$140 of Medicare Approved Amounts**	\$0	\$140 (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

Plan F (continued)

Medicare (Part B) – Medical Services – Per Calendar Year (continued)

Services	Medicare Pays	Plan Pays	You Pay
Blood			
First 3 pints	\$0	All Costs	\$0
Next \$140 of Medicare Approved Amounts*	\$0	\$140 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	\$0	\$0
Parts A & B			
Home Health Care – Medicare-approved services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment:			
First \$140 of Medicare Approved Amounts*	\$0	\$140 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
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

*Once you have been billed \$140 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 K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4,660 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare–approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the items or service.**

Services	Medicare Pays	Plan Pays	You Pay
----------	---------------	-----------	---------

Medicare (Part A) – Hospital Services – Per Benefit Period

**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.

Hospitalization**

Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,156	\$578 (50% of Part A deductible)	\$578 (50% of Part A deductible)◆
61st thru 90th day	All but \$289 a day	\$289 a day	\$0
91st day and after: – While using 60 lifetime reserve days	All but \$578 a day	\$578 a day	\$0
– Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
Additional 365 days – Beyond the additional 365 days	\$0	\$0	All costs

Plan K (continued)

Medicare (Part A) – Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan Pays	You Pay
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 \$144.50 a day	Up to \$72.25 a day	Up to \$72.25 a day♦
101st day and after	\$0	\$0	All costs
Blood			
First 3 pints	\$0	50%	50%♦
Additional amounts	100%	\$0	\$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayments/coinsurance for outpatient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance♦

*****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 K (continued)

Medicare (Part B) – Medical Services – Per Calendar Year

****Once you have been billed \$140 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.

Services	Medicare Pays	Plan Pays	You Pay
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 \$140 of Medicare Approved Amounts*	\$0	\$0	\$140 (Part B deductible)****◆
Preventive Benefits for Medicare-covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$4,660)*
Blood			
First 3 pints	\$0	50%	50%◆
Next \$140 of Medicare Approved Amounts*	\$0	\$0	\$140 (Part B deductible)****◆
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
Clinical Laboratory Services			
Tests for diagnostic services	100%	\$0	\$0

Plan K (continued)

Parts A & B

Services	Medicare Pays	Plan Pays	You Pay
Home Health Care – Medicare-approved services			
Medically necessary skilled care services and medical supplies – Durable medical equipment	100%	\$0	\$0
First \$140 of Medicare-Approved Amounts****	\$0	\$0	\$140 (Part B deductible)◆
Remainder of Medicare-Approved Amounts	80%	10%	10%◆

*****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.

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





Regence

Regence BlueCross BlueShield of Oregon

P.O. Box 1271
Portland, OR 97207-1271

or visit us on the Web at
www.regence.com/medicare

Call toll-free 1-888-REGENCE (1-888-734-3623)

8:30 a.m. to 5 p.m., Pacific time,
Monday through Friday,
or contact your local insurance producer (agent)

TTY users should call 711