

# BlueSelect

## Medicare Select Program

Regence HealthWise  
is an Independent Licensee of the  
Blue Cross and Blue Shield Association



Regence  
*HealthWise*

MS07151-008-CF

**Medicare is very good coverage. But it doesn't pay for everything. There are "gaps" in its coverage. Most people buy additional coverage to take care of those gaps.**

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

## Medicare basics

- You become eligible for Medicare either by “aging in” (turning 65) or qualifying as disabled.
- When you become eligible, you 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 insurance companies.
- Parts A and B don't cover all your medical expenses.
- To cover some of the services that Parts A and B don't, you can purchase one of the following:
  - A **Medicare Supplement** (or “Medigap”) plan, which helps you with Parts A and B deductibles and coinsurance. These plans are standardized and offered by private carriers. BlueSelect falls under this category of plans. You can see any provider who accepts Medicare. Not all carriers offer all Medicare Supplement plans.
  - A **Medicare Advantage** plan, which offers a package of benefits to replace your Medicare coverage. These plans offer benefits that are at least equal to Medicare. Since they're built and run by private carriers, they may have different copays and coinsurance levels. They may also require you to use the carrier's network.

- **Part D** plan. These plans provide coverage for prescription drugs only. (Some Medicare Advantage plans also offer built-in prescription coverage.)
  - Or a combination of these
- 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. If you are considering changing plans and are not sure when you can change, call us at 1-888-REGENCE (1-888-734-3623); TTY 711, Monday through Friday between 8:30 a.m. and 6 p.m. Mountain time.

### **Now for some simple facts about Regence:**

We want to help you make the most of your health care dollar. So, we provide resources that help you when you need care and support you in improving your overall health and wellness. These resources include an interactive Web site—**myRegence.com**—which provides advice and assistance in navigating the health care system. We also offer you access to a number of health-related discounts on goods and services such as prescription drugs at 50,000 pharmacies nationwide, fitness memberships, eyeglasses, hearing aid services and more. Visit our Web site at **[www.regence.com/UT/products/medicare](http://www.regence.com/UT/products/medicare)** for a complete list and more information.

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## Important Contact Information

### Regence

Call us Monday through Friday, between 8:30 a.m. and 6 p.m., Mountain time:

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

TTY: 711

### **We also have many resources available online:**

Product details and forms for all our Medicare Supplement and Regence MedAdvantage (PPO) plans:

**[www.regence.com/UT/products/medicare](http://www.regence.com/UT/products/medicare)**

### Medicare

You can reach Medicare experts 24 hours a day, 7 days a week at:

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

TTY: 1 (877) 486-2048

### **Online resources are also available for:**

general Medicare info: [www.medicare.gov](http://www.medicare.gov)

**When you have questions or need to talk through your options, there are many resources available. Regence staffs highly trained and experienced Medicare experts who are easy to reach and talk to.**

**Unlike standard Medicare Supplement plans, BlueSelect has a network of hospitals that you must use in order to get the most out of your coverage.**

**How does BlueSelect differ?**

To be eligible to purchase a Medicare plan, you must be age 65 or older and have Medicare Parts A and B. For more information on Medicare Supplement policies, review the enclosed booklet “Choosing A Medigap Policy”

- Regence BlueCross BlueShield of Utah offers seven standard Medicare Supplement plans—A, B, C, D, E, F and G.
- Regence HealthWise offers Plans C and F through BlueSelect.

When you purchase Plan C or F through BlueSelect, the premiums are lower.

Also, with standard Medicare Supplement plans, you can see any provider who accepts Medicare. With BlueSelect, you must use the services of the IHC network hospitals listed in this brochure to receive the full value of your BlueSelect plan.

Finally, if those hospitals are used for Part A hospital services, the benefits of BlueSelect Plans C and F are identical to the benefits provided by regular Medicare Supplement Plans C and F.

## BlueSelect Outline of Coverage

### Basic Benefits:

**Hospitalization:** Part A coinsurance plus coverage for 365 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.

Plan C	Plan F
Basic Benefits	Basic Benefits
Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
Part A Deductible*	Part A Deductible*
Part B Deductible	Part B Deductible
	Part B Excess (100%)
Foreign Travel Emergency	Foreign Travel Emergency

*\*In most cases, Part A Deductible and coinsurance amounts are paid only if specified IHC network hospitals are used for Part A hospital services.*

# Premium Information

*Rates effective August 1, 2009*

Regence HealthWise can raise your premium only if we raise the premium for all BlueSelect policies like yours in the state.

BlueSelect plans C and F are the two Medicare Select policies offered by Regence HealthWise. These plans give you the advantage of a lower premium rate when compared to the premium rates for Plans C and F offered under our regular Medicare Supplement plans.

Because of Medicare Select regulations, you must reside in one of the following counties in order to purchase one of the BlueSelect plans: Salt Lake, Weber, Davis or Utah.

Age	Plan C		Plan F	
	Monthly	Quarterly	Monthly	Quarterly
65	\$126	\$378	\$128	\$384
66	\$133	\$399	\$135	\$405
67	\$138	\$414	\$141	\$423
68	\$143	\$429	\$147	\$441
69	\$152	\$456	\$154	\$462
70	\$156	\$468	\$161	\$483
71	\$163	\$489	\$167	\$501
72	\$169	\$507	\$171	\$513
73	\$177	\$531	\$179	\$537
74	\$182	\$546	\$185	\$555
75-79	\$204	\$612	\$207	\$621
80-84	\$222	\$666	\$226	\$678
85+	\$233	\$699	\$237	\$711

## Network Hospitals

The BlueSelect network of participating hospitals includes the following IHC hospitals:

### **Alta View Hospital**

9660 South 1300 East  
Sandy, UT 84094  
Telephone: (801) 501-2600  
Hours: Open 24 hours each day

### **American Fork Hospital**

170 North 1100 East  
American Fork, UT 91203  
Telephone: (801) 855-3586  
Hours: Open 24 hours each day

### **Intermountain Medical Center**

5121 S Cottonwood St  
Murray, UT 84157  
Telephone: (801) 507-7000  
Hours: Open 24 hours each day

### **LDS Hospital**

8th Avenue and C Street  
Salt Lake City, UT 84143  
Telephone: (801) 408-1100  
Hours: Open 24 hours each day

### **McKay-Dee Hospital**

4401 Harrison Blvd.  
Ogden, UT 84403  
Telephone: (801) 387-2800  
Hours: Open 24 hours each day

*(continued on next page)*

### **Orem Community Hospital**

331 North 400 West

Orem, UT 84057

Telephone: (801) 224-4080

Hours: Open 24 hours each day

### **The Orthopedic Specialty Hospital (TOSH)**

5848 South Fashion Blvd

Murray, UT 84107

Telephone: (801) 314-4100

Hours: 7:00 a.m. to 6:00 p.m.

Monday – Friday

### **Utah Valley Regional Medical Center**

1034 North 500 West

Provo, UT 84604

Telephone: (801) 357-7850

Hours: Open 24 hours each day

### **Proximity to network hospitals**

Medicare Select regulations require that purchasers of BlueSelect Plans C or F must live within 30 minutes (approximately 30 miles) of one of the above hospitals. When you use one of these network hospitals for Medicare-approved services, the full benefits of your BlueSelect coverage will be paid.

### **Choosing a physician**

Because hospital benefits under BlueSelect plans are generally provided only when you use network hospitals, it is important that you choose physicians who have privileges in one or more of the network hospitals.

## Required Disclosures

### Hospital network restrictions

BlueSelect is a Medicare SELECT Supplement policy. This means that, in most cases, you must use network hospitals when non-emergency hospital services are required. Benefits will not be paid for services provided in a non-network hospital unless such services:

- are covered by Part B of Medicare;
- are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or condition and it is not reasonable to obtain such services from a network hospital (such as when you are traveling); or
- are not available at a network hospital.

Medicare will pay regular Part A hospital benefits regardless of whether you use network or non-network hospitals. However, except as outlined above, if services are received in a non-network hospital, Regence HealthWise will not pay the Part A deductible, the coinsurance amounts under Part A, nor any of the expenses incurred beyond the period of Medicare coverage.

## **Right to Purchase Other Medicare Supplement Coverage**

Regence BCBSU offers seven standard Medicare Supplement Plans A through G that do not restrict the use of providers. The benefits and premium rates for these policies are explained in the Medicare Supplement Program brochure that accompanies this BlueSelect brochure. You have the right to purchase any of the Medicare Supplement plans that we offer.

If, after you have had a BlueSelect policy for six months, and the BlueSelect program is discontinued, or if you should move outside the service area and your new residence is not within a reasonable travel distance of a network hospital, you may have the right to convert to one of our standard Medicare Supplement plans without proof of insurability and without any waiting periods. The new policy must be of comparable or lesser benefits than your BlueSelect plan, and it will not have a restricted hospital network.

## **Quality Assurance**

Each IHC hospital in our network is licensed by the state of Utah, certified by Medicare, and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In addition, IHC hospitals have an extensive continuous quality improvement program that incorporates specific goals and outcome measures for inpatient clinical quality. The IHC quality improvement program is recognized by the American Hospital Association as a national model and has helped IHC hospitals earn national awards for quality health care.

## Grievance Procedures

### Appeal Process

This section describes the Appeal Process in the event a Member or a Member's Representative (any representative authorized by the Member) has a complaint or grievance regarding a claim denial or other action by Regence HealthWise under this plan and wishes to have it reviewed. A request for appeal must be submitted to Regence HealthWise within 180 days of the claim denial or other action giving rise to the complaint or grievance. Failure to appeal within this time period will preclude all further rights to appeal or contest the action in any forum.

**Note:** In the event the Member or the Member's Representative reasonably believes that a utilization management decision denying preauthorization of a pre-service claim could jeopardize the Member's life, health or ability to regain maximum function or, according to a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the disputed care or treatment, the Member or the Member's Representative may request an Expedited Appeal. For procedures, see "Expedited Appeals" on page 17.

# Appeals

## ***First Level – Complaint/Grievance/Reconsideration***

A Member may initiate an appeal through either a written or oral request. Written appeal requests should be mailed to Benefits Administration, Regence HealthWise, P.O. Box 30804, Salt Lake City, Utah 84130-0804. Oral requests can be made by calling Customer Service at (801) 333-2100 within the Salt Lake area or 1 (800) 624-6519 outside the Salt Lake area. Within 5 working days or 7 calendar days, whichever is sooner, of the receipt of request for an appeal, Benefits Administration will send to the member an acknowledgement of the request for appeal and information describing the entire Appeal Process and the Member's rights. If additional information is needed to complete the review, Customer Service will send notice of the delay within 30 days of receipt of the appeal request. "First Level - Complaint/Grievance/Reconsideration" is a review by a Benefits Administration Representative who was not involved in the initial decision. In the case of an appeal involving a decision requiring medical judgment, the Benefits Administration Representative will consult with one of the Regence HealthWise Medical Services physicians prior to rendering a decision. If the Member's provider requests reconsideration of a denial of preauthorization, a peer-to-peer discussion with one of the Regence HealthWise Medical Services physicians is offered and arranged within 1 working day of the request. A written notice of the decision will be sent within 30 days of receipt of the request for an appeal, except when additional information is needed. In that case, the total review period will not exceed 45 days from receipt of the initial request for appeal.

## ***Second Level – Internal Appeal***

If a Member disagrees with the decision made in the “First Level – Complaint/Grievance/Reconsideration,” the Member may request further appeal to the “Second Level – Internal Appeal.” The appeal request must be made within 180 days after the Member receives notice of the decision at the “First Level – Complaint/Grievance/Reconsideration.” Failure to request a “Second Level – Internal Appeal” within this time period will preclude the Member’s right to further appeal of the decision in any forum. The appeal request, including any additional information or comments, must be made to the Appeal Coordinator, Regence HealthWise, P.O. Box 30804, Salt Lake City, Utah 84130-0804. Within 5 working days or 7 calendar days, whichever is sooner, of the receipt of the request for “Second Level – Internal Appeal,” the Appeal Coordinator will send to the member information describing the entire Appeal Process and the Member’s rights. “Second Level – Internal Appeal” is a review by a panel comprised of the Appeal Coordinator, one of the Regence HealthWise Medical Services physicians and another officer of Regence HealthWise, none of whom were involved in the First Level decision. The Member or the Member’s Representative, on the Member’s behalf, will be given a reasonable opportunity to personally appear or participate via telephone, video conference, or other technology, and/or to provide written materials. For appeals involving a post-service investigational or experimental issue, a written notice of the decision will be sent within 20 working days or 30 calendar days, if sooner, of receipt of the “Second Level – Internal Appeal,” and within 5 working days of the decision being made. For appeals involving a pre-service preauthorization of a procedure, including a pre-service investigational procedure, a written notice of the decision will be sent within 14 days of receipt of the “Second Level – Internal Appeal,” and within 5 working days of the decision being made, except when additional information is needed. In

that case, the total review period will not exceed 30 days from receipt of the initial request for “Second Level – Internal Appeal.” For all other appeals, a written notice of the decision will be sent within 30 days of receipt of the request for “Second Level – Internal Appeal” and within 5 working days of the decision being made.

### ***Third Level – External Appeal***

If a Member disagrees with the decision made in the “Second Level – Internal Appeal” (or if a Member disagrees with the decision made in a “First Level – Expedited Appeal” [described on the following page]), but preauthorization could no longer be reasonably believed to be clinically urgent [e.g., the service has been provided]), the Member may request further appeal to the “Third Level – External Appeal.” The appeal request must be made within 180 days after the Member receives notice of the decision at the “Second Level – Internal Appeal.” Failure to request a “Third Level – External Appeal” within this time period will preclude the Member’s right to further appeal of the decision in any forum. The appeal request, including any additional information or comments, must be made to the Appeal Coordinator, Regence HealthWise, P. O. Box 30804, Salt Lake City, Utah 84130-0804. “Third Level – External Appeal” will be coordinated by the Appeal Coordinator while the decision is made by an Independent Review Organization (IRO). The IRO is an independent physician review organization which is unbiased, independent and not controlled by Regence HealthWise. Within the IRO, there will be clinical expertise, use of evidence-based decision making, maintenance of confidentiality, and adequate administration and training capacity. Within 5 days of receipt of the request for a “Third Level – External Appeal,” the Appeal Coordinator will send to the member information describing the entire Appeal process and the Member’s rights. The Appeal Coordinator will provide the IRO with the appeal documentation within 3 working days and a written notice of the decision will be sent by

the IRO within 15 days of receipt of the request for “Third Level – External Appeal,” or within 20 days of the initial request for “Third Level – External Appeal,” whichever is sooner, except when additional information is needed. In that case, the total review period will not exceed 25 days from receipt of the initial request for “Third Level – External Appeal.”

***Optional Fourth Level – Arbitration***

Arbitration is available as the final level of appeal for a dispute a Member has with Regence HealthWise. All other levels of this Appeal Process must be exhausted before arbitration is available. Choosing arbitration as the final level for the settlement of such disputes will be binding in accordance with the Arbitration provision of this section. The Appeal Coordinator can assist the Member with procedures for initiating and participating in arbitration. Other forums may be utilized in lieu of arbitration as the final level of appeal to resolve a dispute a Member has with Regence HealthWise including, but not limited to, mediation or civil action.

# Expedited Appeals

## ***First Level – Expedited Appeal***

If a Member or a Member's Representative reasonably believes that a utilization management decision denying preauthorization of a pre-service claim could jeopardize the Member's life, health or ability to regain maximum function, or, according to a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the disputed care or treatment, the Member or the Member's Representative may request an Expedited Appeal. The appeal request must be made verbally or in writing within 180 days after the Member receives notice of the initial written preauthorization denial, state the need for a decision on an expedited basis, and include documentation necessary for the appeal decision. The appeal request, including any additional information or comments, must be made to the Appeal Coordinator, Regence HealthWise, P.O. Box 30804, Salt Lake City, Utah 84130-0804.

The "First Level – Expedited Appeal" is a review by a Panel comprised of the Appeal Coordinator, one of the Regence HealthWise Medical Services physicians and another officer of Regence HealthWise, none of whom were involved in the initial denial. A verbal notice of the decision will be provided to the Member and the Member's Representative as soon as possible after the decision, but no later than 1 working day or 72 hours of receipt of the request for "First Level – Expedited Appeal," whichever is sooner, and a written notice will be provided within 1 working day of providing the verbal notification.

### ***Second Level – Expedited Appeal***

If a Member disagrees with the decision made in the “First Level – Expedited Appeal,” and the Member or the Member’s Representative reasonably believes that preauthorization remains clinically urgent (pre-service), the Member may request further appeal to the “Second Level – Expedited Appeal.” The appeal request must be made verbally or in writing within 180 days after the Member receives either the verbal or written notice of the decision at the “First Level – Expedited Appeal.” Failure to request a “Second Level – Expedited Appeal” within this time period will preclude the Member’s right to further appeal of the decision in any forum. The appeal request, including any additional information or comments, must be made to the Appeal Coordinator, Regence HealthWise, P.O. Box 30804, Salt Lake City, Utah 84130-0804. A “Second Level – Expedited Appeal” will be coordinated by the Appeal Coordinator while the decision is made by an Independent Review Organization (IRO). The IRO is an independent physician review organization which is unbiased, independent and not controlled by Regence HealthWise. Within the IRO, there will be clinical expertise, use of evidence-based decision making, maintenance of confidentiality, and adequate administration and training capacity. Immediately upon receipt of the request for a “Second Level – Expedited Appeal,” the Appeal Coordinator will provide the IRO with the appeal documentation. A verbal notice of the decision will be provided by the IRO to the Member or the Member’s Representative as soon as possible after the decision, but no later than 1 working day or 72 hours of receipt of the request for “Second Level – Expedited Appeal,” whichever is sooner, and a written notice will be provided by the IRO within 1 working day of providing the verbal notification.

### ***Optional Third Level – Expedited Appeal***

Arbitration is available as the final level of appeal for a dispute a Member has with Regence HealthWise. All other levels of this Appeal Process must be exhausted before arbitration is available. Choosing arbitration as the final level for the settlement of such disputes will be binding in accordance with the Arbitration provision of this section. The Appeal Coordinator can assist the Member with procedures for initiating and participating in arbitration. Other forums may be utilized in lieu of arbitration as the final level of appeal to resolve a dispute the Member has with Regence HealthWise including, but not limited to, mediation or civil action.

## **Arbitration (if opted)**

In the event of any dispute or controversy concerning the construction, interpretation, performance or breach of the Contract arising between a Member or a Member's heir-at-law or Representative, and Regence HealthWise, whether involving a claim in tort, contract or otherwise, the same may be submitted, if opted by the Member as the final level of appeal, to arbitration under the appropriate rules of the American Arbitration Association, a copy of which is available upon request from the Regence HealthWise Customer Service department or the local office of the American Arbitration Association. All administrative remedies described in this Contract must be exhausted prior to the demand for arbitration. The costs of arbitration, including reasonable filing fees, administrative fees and arbitrator fees, will be borne by Regence HealthWise. Other expenses of arbitration (including but not limited to attorney fees, expenses of discovery, witnesses, stenographers, translators, and similar expenses) will be borne by the party incurring those expenses. The parties agree that the arbitrator's award will be binding, may include attorney's fees if allowed by state law, and may be enforced in any court having jurisdiction thereof by filing a petition for enforcement of said award. Any arbitration will be conducted in Salt Lake City, Utah, unless mutually agreed otherwise by the parties.

## General Disclosures

### **Compare policy benefits and premiums**

Accompanying this brochure is a *Guide To Health Insurance for People with Medicare*, and a Medicare Supplement Program booklet which describes the benefits and premiums of the seven standard Medicare supplement plans offered by Regence BlueCross BlueShield of Utah. Use this information and the data contained in this BlueSelect brochure to compare benefits and premiums among policies before completing your application.

### **Read your policy very carefully**

This is only an outline describing your policy's 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 2890 East Cottonwood Parkway, Salt Lake City, Utah 84121. 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.

## **Notices**

This policy may not fully cover all of your medical costs.

### ***Neither Regence HealthWise 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 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.

# **BlueSelect Plans C & F Comparison**

## BlueSelect Plans C & F

Services	Medicare Pays		Plan C		Plan F	
	Medicare Pays – per benefit period		Plan C Pays	You Pay	Plan F Pays	You Pay
<b>MEDICARE (PART A)</b> — Hospital Services – per benefit period						
<b>Hospitalization*</b> — Semi-private room & board, general nursing and miscellaneous services and supplies						
First 60 days	All but \$1,068	\$1,068 (Part A Deductible)	\$0	\$0	\$1,068 Part A Deductible)	\$0
61st through 90th day	All but \$267/day	\$267/day	\$0	\$0	\$267/day	\$0
91st day and after: While using 60 lifetime reserve days	All but \$534/day	\$534/day	\$0	\$0	\$534/day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**	100% of Medicare Eligible Expenses	100% of Medicare Eligible Expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All Costs	All Costs	\$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 up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited billed charges and the amount Medicare would have paid.

## BlueSelect Plans C & F (continued)

Services	Medicare Pays	Plan C		Plan F	
		Plan C Pays	You Pay	Plan F Pays	You Pay
<b>MEDICARE (PART A)</b> Hospital Services – per benefit period (continued)					
<b>Skilled Nursing Facility Care*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital					
First 20 days	All approved amounts	\$0	\$0	\$0	\$0
21st through 100th Day	All but \$133.50 a day	Up to \$133.50 a day	\$0	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All Costs	\$0	All Costs
<b>Blood</b>					
First 3 pints	\$0	3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0	\$0	\$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.

## BlueSelect Plans C & F (continued)

Services	Medicare Pays		Plan C		Plan F	
	Plan C Pays	You Pay	Plan C Pays	You Pay	Plan F Pays	You Pay
<b>MEDICARE (PART A)</b>						
Hospital Services – per benefit period (continued)						
<b>Hospice Care</b>						
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	\$0	Balance	\$0	Balance	\$0	Balance
<b>MEDICARE (PART B)</b>						
Medical Services – per calendar year	<b>Plan C Pays</b>	<b>You Pay</b>	<b>Plan C Pays</b>	<b>You Pay</b>	<b>Plan F Pays</b>	<b>You Pay</b>
<b>Medicare Expenses – in and out of hospital and outpatient hospital treatment</b> , such as physician's services, inpatient and outpatient medical and surgical expenses and supplies, physical and speech therapy, diagnostic tests, durable medical equipment						
First \$135 of Medicare-Approved Amounts***	\$0	\$0	\$135 (Part B Deductible)	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	Generally 80%	\$0	Generally 20%	\$0	Generally 20%	\$0

\*\*\* Once you have been billed \$135 of Medicare Approved Amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

## BlueSelect Plans C & F (continued)

Services	Medicare Pays	Plan C		Plan F	
		Plan C Pays	You Pay	Plan F Pays	You Pay
<b>MEDICARE (PART B)</b>					
Medical Services – per calendar year (continued)					
<b>Medicare Expenses (continued)</b>					
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All Costs	100%	\$0
<b>Blood</b>					
First 3 pints	\$0	All Costs	\$0	All Costs	\$0
Next \$135 of Medicare-Approved Amounts***	\$0	\$135 (Part B Deductible)	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0	20%	\$0
<b>Clinical Laboratory Services</b>					
Blood tests for diagnostic services	100%	\$0	\$0	\$0	\$0

\*\*\* Once you have been billed \$135 of Medicare Approved Amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

## BlueSelect Plans C & F (continued)

Services	Medicare Pays		Plan C		Plan F	
	Plan C Pays	You Pay	Plan C Pays	You Pay	Plan F Pays	You Pay
<b>PARTS A &amp; B</b>						
<b>Home Health Care – Medicare-approved services</b>						
Medically necessary skilled care services and medical supplies		100%	\$0	\$0	\$0	\$0
Durable medical equipment						
First \$135 of Medicare-Approved Amounts***		\$0	\$135 (Part B Deductible)	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts		80%	20%	\$0	20%	\$0

\*\*\* Once you have been billed \$135 of Medicare Approved Amounts for covered services (which are noted with asterisks), your Part B Deductible will have been met for the calendar year.

## BlueSelect Plans C & F (continued)

Services	Medicare Pays		Plan C		Plan F	
OTHER BENEFITS not covered by Medicare	Plan C Pays	You Pay	Plan F Pays	You Pay	Plan F Pays	You Pay
<b>Foreign Travel – not covered by Medicare</b>						
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA						
First \$250 each calendar year	\$0		\$0	\$250	\$0	\$0
Remainder of charges	\$0		80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

## What Is Not Covered

### Underwriting requirements

If you are age 65 or older and you enroll within six months of your Medicare Part B effective date, you are not subject to any Regence HealthWise underwriting requirements.

### No benefits are provided for:

- Inpatient care received in a non-network hospital unless on an emergency basis
- Private duty nursing
- Services excluded by Medicare
- Custodial nursing home costs
- Intermediate nursing home costs
- Home health care if the patient is not homebound
- Services considered not medically necessary
- Dental care, dentures, physicals, routine immunizations, cosmetic surgery, routine care examinations, the cost of hearing aids or eyeglasses except when eyeglasses are required following cataract surgery
- Injuries or disease covered under Workers Compensation or other liability insurance which is primary
- Services provided by an employer-sponsored program or service covered under federal, state or local laws
- Disease contracted or injury sustained as a result of war
- Services or supplies not ordered by an attending physician
- Services of blood donors
- Services to a subscriber confined to a hospital or extended care facility on the effective date, so long as subscriber is continuously confined
- Services covered and paid or which could have been covered and paid by Medicare

# Payment Plan Options

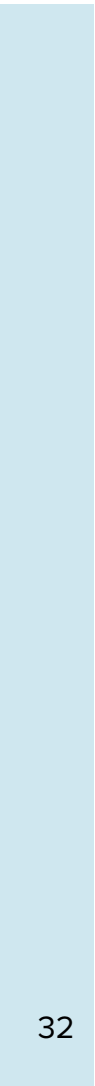
## Direct Quarterly Bill

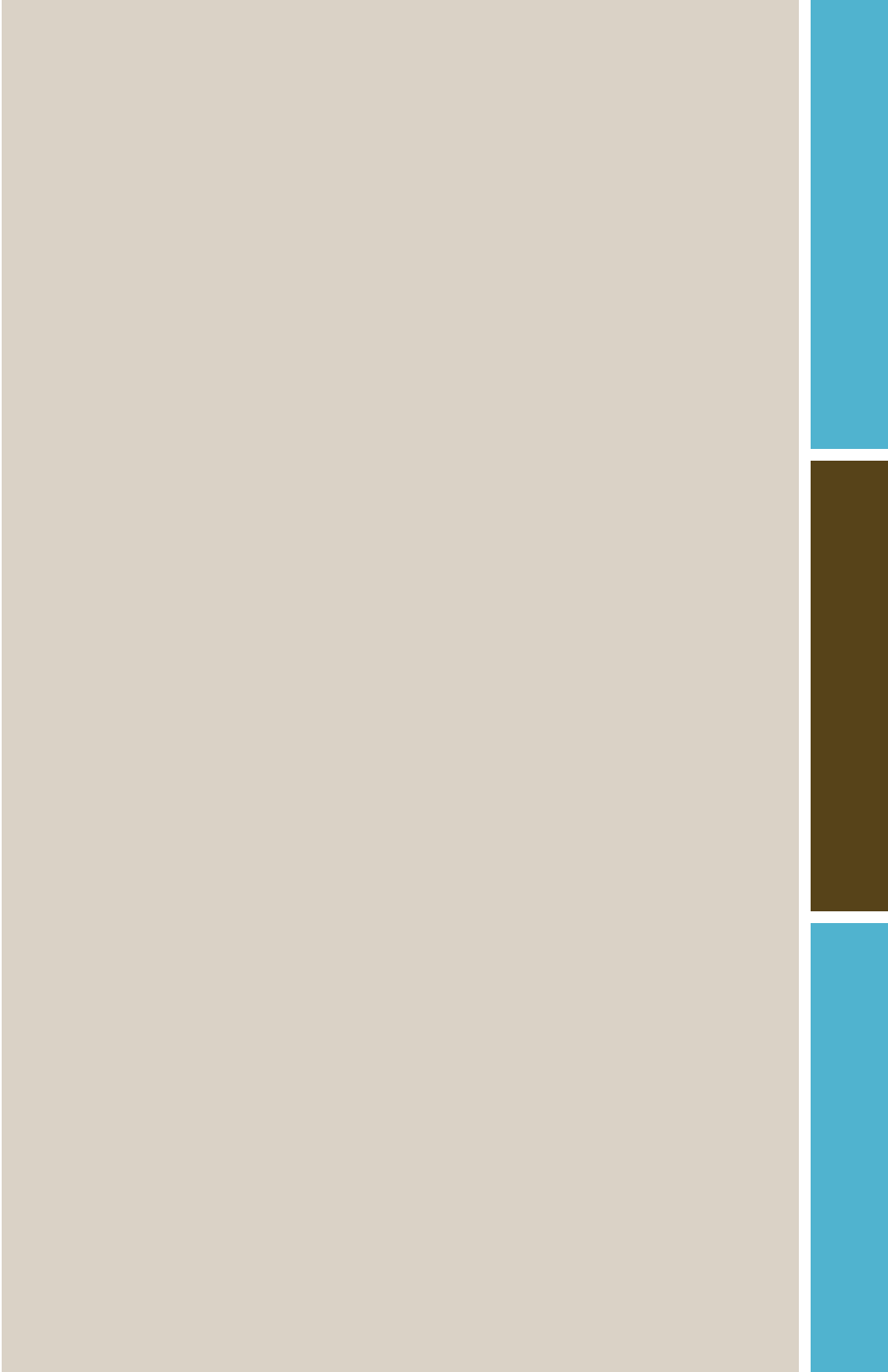
If you choose, you can receive a direct quarterly billing, mailed to your home address as indicated on your application.

## Surepay

SurePay allows you to have your premium withdrawn automatically each month from your personal checking account. Payments are made monthly rather than quarterly, making your budgeting process much easier. SurePay eliminates postage as well as the time and expense of writing checks. It is not necessary to send in your first month's premium with your application. Generally, we will automatically deduct it from your checking account. **Please note:** Occasionally, applications are received and processed without time for Surepay to be set up. In these instances, we will send you a bill for the premium due until the Surepay draft can be set up.

When completing your application, select one of the two payment options on the application form. A SurePay form is enclosed for your convenience when selecting this option.





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Toll-free 1-888-REGENCE  
(1-888-734-3623)  
8:30 a.m. to 6 p.m. Mountain time

TTY users should call 711

**[www.regence.com/UT/products/medicare](http://www.regence.com/UT/products/medicare)**

