Medicare Supplement Plans

(Medigap Plans)

for Clark County, Washington

Outline of Coverage

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Regence

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

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 $2,000 calendar year deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

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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 $4,620; paid at 100% after limit reached	Out-of-pocket limit $2,310; paid at 100% after limit reached		

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Premium Information – Medicare Supplement Plans

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 June 1, 2010

	Plan A	Plan C	Plan F	Plan K
Monthly Surepay Rate	$124	$175	$176	$94
Monthly Paper Bill Rate	$126	$177	$178	$96
Quarterly Rate	$374	$527	$530	$284
Semi-Annual Rate	$746	$1,052	$1,058	$566
Annual Rate	$1,490	$2,102	$2,114	$1,130

Discounts are reflected in the premiums listed above for all payment options other than Monthly Paper Bill; there is no discount for monthly paper billing.

- Monthly Surepay from your bank account receives a discount of $2 – a $24 savings annually
- Paying your bill quarterly saves you $4 – a $16 savings annually
- Paying your bill semi-annually saves you $10 – a $20 savings annually
- Paying your bill annually saves you $22

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 $1,100	$0	$1,100 (Part A deductible)
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $550 a day	$550 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 $137.50 a day	$0	Up to $137.50 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 $155 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 $155 of Medicare Approved Amounts*	$0	$0	$155 (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 $155 of Medicare Approved Amounts*	$0	$0	$155 (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 $155 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 80%	 $0 20%	 $155 (Part B deductible) $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 $1,100	$1,100 (Part A deductible)	$0
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $550 a day	$550 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 $137.50 a day	Up to $137.50 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 $155 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 $155 of Medicare Approved Amounts*	$0	$155 (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 $155 of Medicare Approved Amounts*	$0	$155 (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 $155 of Medicare Approved Amounts*	$0	$155 (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 $1,100	$1,100 (Part A deductible)	$0
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $550 a day	$550 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 $137.50 a day	Up to $137.50 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 $155 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 $155 of Medicare Approved Amounts**	$0	$155 (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 $155 of Medicare Approved Amounts*	$0	$155 (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 $155 of Medicare Approved Amounts*	$0	$155 (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 $155 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 $4,620 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 $1,100	$550 (50% of Part A deductible)	$550 (50% of Part A deductible)◆
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after: – While using 60 lifetime reserve days	All but $550 a day	$550 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 $137.50 a day	Up to $68.75 a day	Up to $68.75 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 $155 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 $155 of Medicare Approved Amounts****	$0	$0	$155 (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 outof-pocket limit of $4620)*
Blood			
First 3 pints	$0	50%	50%◆
Next $155 of Medicare Approved Amounts*	$0	$0	$155 (Part B deductible)****◆
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%◆
Clinical Laboratory Services			
Tests for diagnostic services	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $4620 per 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 the difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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	100%	$0	$0
– Durable medical equipment			
First $155 of Medicare Approved Amounts*****	$0	$0	$155 (Part B deductible)◆
Remainder of Medicare Approved Amounts	80%	10%	10%◆

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

Regence

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or visit us on the web at
www.regence.com/OR/products/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

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