Regence

REGENCE BRIDGE

Outline of Coverage

For plan effective dates January 1, 2024 - December 31, 2024

Medicare Supplement (Medigap) plans A, C, F, G, K and N

Regence BlueCross BlueShield of Oregon

REG-OR-36344-23/07

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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.

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 charges (100%)	Part B excess charges (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.* ***Regence BlueCross BlueShield of Oregon does not offer a high deductible Plan F**. The high deductible plan pays the same benefits as Plan F after one has paid a $2,800 calendar year deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,800. 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 $7,060; paid at 100% after limit reached	Out-of-pocket limit $3,530; paid at 100% after limit reached		

Premium information—Female non-smoker, includes all discounts

Rates effective January 1, 2024

Regence BlueCross BlueShield of Oregon can raise your premium only if we raise the premium for all policies like yours in this state. Premiums are based on your age and gender and whether you smoke. Premiums may increase as you get older.

Your rate may change at your renewal date. Rates are guaranteed not to increase for 12 months after your renewal date. You may receive a monthly premium discount of $45 if you qualify for our household discount. You qualify if **(1)** you reside with a spouse or domestic partner of any age, or **(2)** you currently reside with at least one, but no more than three, other adults who are age 60 or older. The household discount will be removed if the other person no longer resides with you, other than in the case of his or her death.

Female monthly plan rates with EFT[1] and household discounts

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Non-smoker**					
<65	$111	$190	$192	$148	$70	$120
65	$111	$190	$192	$148	$70	$120
66	$111	$204	$205	$148	$70	$120
67	$111	$217	$218	$148	$70	$120
68	$119	$232	$233	$157	$76	$128
69	$126	$242	$244	$167	$81	$136
70	$134	$257	$259	$176	$87	$144
71	$141	$268	$269	$185	$92	$152
72	$148	$282	$283	$194	$98	$160
73	$156	$289	$291	$204	$103	$168
74	$163	$301	$303	$213	$109	$176
75	$171	$313	$314	$222	$114	$184
76	$178	$322	$324	$231	$120	$192
77	$186	$337	$339	$241	$125	$200
78	$193	$344	$345	$250	$131	$208
79	$201	$348	$351	$259	$136	$215
80	$208	$357	$359	$268	$142	$223
81	$216	$364	$366	$278	$147	$231
82	$223	$371	$373	$287	$153	$239
83	$231	$380	$382	$296	$158	$247
84	$238	$386	$388	$305	$164	$255
85	$246	$389	$391	$315	$169	$263
86	$253	$389	$391	$324	$175	$271
87	$261	$389	$391	$333	$180	$279
88	$268	$389	$391	$343	$186	$287
89	$276	$389	$391	$352	$191	$295
90+	$283	$389	$391	$361	$197	$303

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Premium information—Female non-smoker, EFT discount

Rates effective January 1, 2024

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Female monthly plan rates with EFT[1] discount

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Non-smoker**					
<65	$156	$235	$237	$193	$115	$165
65	$156	$235	$237	$193	$115	$165
66	$156	$249	$250	$193	$115	$165
67	$156	$262	$263	$193	$115	$165
68	$164	$277	$278	$202	$121	$173
69	$171	$287	$289	$212	$126	$181
70	$179	$302	$304	$221	$132	$189
71	$186	$313	$314	$230	$137	$197
72	$193	$327	$328	$239	$143	$205
73	$201	$334	$336	$249	$148	$213
74	$208	$346	$348	$258	$154	$221
75	$216	$358	$359	$267	$159	$229
76	$223	$367	$369	$276	$165	$237
77	$231	$382	$384	$286	$170	$245
78	$238	$389	$390	$295	$176	$253
79	$246	$393	$396	$304	$181	$260
80	$253	$402	$404	$313	$187	$268
81	$261	$409	$411	$323	$192	$276
82	$268	$416	$418	$332	$198	$284
83	$276	$425	$427	$341	$203	$292
84	$283	$431	$433	$350	$209	$300
85	$291	$434	$436	$360	$214	$308
86	$298	$434	$436	$369	$220	$316
87	$306	$434	$436	$378	$225	$324
88	$313	$434	$436	$388	$231	$332
89	$321	$434	$436	$397	$236	$340
90+	$328	$434	$436	$406	$242	$348

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Premium information—Female smoker, includes all discounts

Rates effective January 1, 2024

Regence BlueCross BlueShield of Oregon can raise your premium only if we raise the premium for all policies like yours in this state. Premiums are based on your age and gender and whether you smoke. Premiums may increase as you get older.

Your rate may change at your renewal date. Rates are guaranteed not to increase for 12 months after your renewal date. You may receive a monthly premium discount of $45 if you qualify for our household discount. You qualify if **(1)** you reside with a spouse or domestic partner of any age, or **(2)** you currently reside with at least one, but no more than three, other adults who are age 60 or older. The household discount will be removed if the other person no longer resides with you, other than in the case of his or her death.

Female monthly plan rates with EFT[1] and household discounts

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Smoker**					
<65	$139	$231	$234	$182	$90	$149
65	$139	$231	$234	$182	$90	$149
66	$139	$248	$249	$182	$90	$149
67	$139	$263	$264	$182	$90	$149
68	$148	$281	$282	$193	$97	$159
69	$156	$293	$295	$204	$103	$168
70	$166	$310	$313	$215	$110	$177
71	$174	$323	$324	$226	$116	$187
72	$182	$340	$341	$236	$123	$196
73	$191	$348	$350	$248	$129	$206
74	$200	$362	$364	$259	$136	$215
75	$209	$376	$377	$269	$142	$224
76	$217	$387	$389	$280	$149	$234
77	$227	$404	$407	$291	$155	$243
78	$235	$413	$414	$302	$162	$253
79	$244	$417	$421	$313	$168	$261
80	$253	$428	$430	$323	$175	$270
81	$262	$436	$439	$335	$181	$280
82	$270	$444	$447	$346	$188	$289
83	$280	$455	$457	$356	$194	$299
84	$288	$462	$464	$367	$201	$308
85	$297	$466	$468	$379	$207	$317
86	$306	$466	$468	$389	$214	$327
87	$315	$466	$468	$400	$220	$336
88	$323	$466	$468	$411	$227	$346
89	$333	$466	$468	$422	$233	$355
90+	$341	$466	$468	$433	$240	$364

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Premium information—Female smoker, EFT discount

Rates effective January 1, 2024

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Female monthly plan rates with EFT[1] discount

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Smoker**					
<65	$184	$276	$279	$227	$135	$194
65	$184	$276	$279	$227	$135	$194
66	$184	$293	$294	$227	$135	$194
67	$184	$308	$309	$227	$135	$194
68	$193	$326	$327	$238	$142	$204
69	$201	$338	$340	$249	$148	$213
70	$211	$355	$358	$260	$155	$222
71	$219	$368	$369	$271	$161	$232
72	$227	$385	$386	$281	$168	$241
73	$236	$393	$395	$293	$174	$251
74	$245	$407	$409	$304	$181	$260
75	$254	$421	$422	$314	$187	$269
76	$262	$432	$434	$325	$194	$279
77	$272	$449	$452	$336	$200	$288
78	$280	$458	$459	$347	$207	$298
79	$289	$462	$466	$358	$213	$306
80	$298	$473	$475	$368	$220	$315
81	$307	$481	$484	$380	$226	$325
82	$315	$489	$492	$391	$233	$334
83	$325	$500	$502	$401	$239	$344
84	$333	$507	$509	$412	$246	$353
85	$342	$511	$513	$424	$252	$362
86	$351	$511	$513	$434	$259	$372
87	$360	$511	$513	$445	$265	$381
88	$368	$511	$513	$456	$272	$391
89	$378	$511	$513	$467	$278	$400
90+	$386	$511	$513	$478	$285	$409

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Premium information—Male non-smoker, includes all discounts

Rates effective January 1, 2024

Regence BlueCross BlueShield of Oregon can raise your premium only if we raise the premium for all policies like yours in this state. Premiums are based on your age and gender and whether you smoke. Premiums may increase as you get older.

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Male monthly plan rates with EFT[1] and household discounts

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Non-smoker**					
<65	$126	$190	$192	$166	$81	$136
65	$126	$190	$192	$166	$81	$136
66	$126	$204	$205	$166	$81	$136
67	$126	$217	$218	$166	$81	$136
68	$134	$232	$233	$176	$87	$145
69	$142	$242	$244	$186	$93	$153
70	$150	$257	$259	$197	$99	$162
71	$159	$268	$269	$207	$105	$171
72	$167	$282	$283	$217	$111	$179
73	$175	$289	$291	$227	$117	$188
74	$183	$301	$303	$237	$123	$197
75	$191	$313	$314	$247	$129	$205
76	$200	$322	$324	$257	$135	$214
77	$208	$337	$339	$268	$141	$223
78	$216	$344	$345	$278	$147	$231
79	$224	$348	$351	$288	$153	$240
80	$232	$357	$359	$298	$159	$249
81	$240	$364	$366	$308	$165	$257
82	$249	$371	$373	$318	$171	$266
83	$257	$380	$382	$328	$177	$275
84	$265	$386	$388	$339	$183	$283
85	$273	$389	$391	$349	$190	$292
86	$281	$389	$391	$359	$196	$301
87	$290	$389	$391	$369	$202	$309
88	$298	$389	$391	$379	$208	$318
89	$306	$389	$391	$389	$214	$327
90+	$314	$389	$391	$399	$220	$336

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Premium information—Male non-smoker, EFT discount

Rates effective January 1, 2024

Regence BlueCross BlueShield of Oregon can raise your premium only if we raise the premium for all policies like yours in this state. Premiums are based on your age and gender and whether you smoke. Premiums may increase as you get older.

Your rate may change at your renewal date. Rates are guaranteed not to increase for 12 months after your renewal date.

Male monthly plan rates with EFT[1] discount

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Non-smoker**					
<65	$171	$235	$237	$211	$126	$181
65	$171	$235	$237	$211	$126	$181
66	$171	$249	$250	$211	$126	$181
67	$171	$262	$263	$211	$126	$181
68	$179	$277	$278	$221	$132	$190
69	$187	$287	$289	$231	$138	$198
70	$195	$302	$304	$242	$144	$207
71	$204	$313	$314	$252	$150	$216
72	$212	$327	$328	$262	$156	$224
73	$220	$334	$336	$272	$162	$233
74	$228	$346	$348	$282	$168	$242
75	$236	$358	$359	$292	$174	$250
76	$245	$367	$369	$302	$180	$259
77	$253	$382	$384	$313	$186	$268
78	$261	$389	$390	$323	$192	$276
79	$269	$393	$396	$333	$198	$285
80	$277	$402	$404	$343	$204	$294
81	$285	$409	$411	$353	$210	$302
82	$294	$416	$418	$363	$216	$311
83	$302	$425	$427	$373	$222	$320
84	$310	$431	$433	$384	$228	$328
85	$318	$434	$436	$394	$235	$337
86	$326	$434	$436	$404	$241	$346
87	$335	$434	$436	$414	$247	$354
88	$343	$434	$436	$424	$253	$363
89	$351	$434	$436	$434	$259	$372
90+	$359	$434	$436	$444	$265	$381

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Premium information—Male smoker, includes all discounts

Rates effective January 1, 2024

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Male monthly plan rates with EFT[1] and household discounts

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Smoker**					
<65	$156	$231	$234	$203	$103	$168
65	$156	$231	$234	$203	$103	$168
66	$156	$248	$249	$203	$103	$168
67	$156	$263	$264	$203	$103	$168
68	$166	$281	$282	$215	$110	$179
69	$175	$293	$295	$227	$117	$188
70	$184	$310	$313	$240	$124	$199
71	$195	$323	$324	$251	$131	$209
72	$204	$340	$341	$263	$139	$219
73	$214	$348	$350	$275	$146	$229
74	$223	$362	$364	$287	$153	$240
75	$233	$376	$377	$299	$160	$249
76	$243	$387	$389	$310	$167	$260
77	$253	$404	$407	$323	$174	$270
78	$262	$413	$414	$335	$181	$280
79	$271	$417	$421	$347	$188	$290
80	$281	$428	$430	$359	$195	$301
81	$290	$436	$439	$370	$202	$310
82	$301	$444	$447	$382	$209	$321
83	$310	$455	$457	$394	$216	$331
84	$320	$462	$464	$407	$223	$341
85	$329	$466	$468	$419	$231	$351
86	$339	$466	$468	$430	$239	$362
87	$349	$466	$468	$442	$246	$371
88	$359	$466	$468	$454	$253	$382
89	$368	$466	$468	$466	$260	$393
90+	$377	$466	$468	$477	$267	$403

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Premium information—Male smoker, EFT discount

Rates effective January 1, 2024

Regence BlueCross BlueShield of Oregon can raise your premium only if we raise the premium for all policies like yours in this state. Premiums are based on your age and gender and whether you smoke. Premiums may increase as you get older.

Your rate may change at your renewal date. Rates are guaranteed not to increase for 12 months after your renewal date.

Male monthly plan rates with EFT[1] discount

	Plan A	Plan C	Plan F	Plan G	Plan K	Plan N
Age	**Smoker**					
<65	$201	$276	$279	$248	$148	$213
65	$201	$276	$279	$248	$148	$213
66	$201	$293	$294	$248	$148	$213
67	$201	$308	$309	$248	$148	$213
68	$211	$326	$327	$260	$155	$224
69	$220	$338	$340	$272	$162	$233
70	$229	$355	$358	$285	$169	$244
71	$240	$368	$369	$296	$176	$254
72	$249	$385	$386	$308	$184	$264
73	$259	$393	$395	$320	$191	$274
74	$268	$407	$409	$332	$198	$285
75	$278	$421	$422	$344	$205	$294
76	$288	$432	$434	$355	$212	$305
77	$298	$449	$452	$368	$219	$315
78	$307	$458	$459	$380	$226	$325
79	$316	$462	$466	$392	$233	$335
80	$326	$473	$475	$404	$240	$346
81	$335	$481	$484	$415	$247	$355
82	$346	$489	$492	$427	$254	$366
83	$355	$500	$502	$439	$261	$376
84	$365	$507	$509	$452	$268	$386
85	$374	$511	$513	$464	$276	$396
86	$384	$511	$513	$475	$284	$407
87	$394	$511	$513	$487	$291	$416
88	$404	$511	$513	$499	$298	$427
89	$413	$511	$513	$511	$305	$438
90+	$422	$511	$513	$522	$312	$448

(1) If your monthly premium is not paid by electronic fund transfer (EFT), add $2 to the amount to calculate the monthly paper billing rate.

Disclosures

Use this outline to compare benefits and premiums among policies. **This outline shows benefits and premiums of policies sold for effective dates on or after January 1, 2020.**

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
P.O. Box 1106
Lewiston, ID 83501

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 less any claims paid.

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 producers 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 complete 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.

Regence BlueCross BlueShield of Oregon

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. The plans offered by Regence BlueCross BlueShield of Oregon are shaded in the chart below. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F and high deductible F. **Note:** A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G*	K	L	M	N	C	F*
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ Copays apply***	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility Coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2024**					$7,060**	$3,530**				

Plans F and G also have a high deductible option which require first paying a plan deductible of $2,800 before the plan begins to pay.* ***Regence BlueCross BlueShield of Oregon does not offer a high deductible Plan F or G**. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.*

***Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.*

****Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.*

Medigap 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 and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$0	$1,632 (Part A deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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 (cont.)

Medicare (Part B) – medical services – per calendar year

***Once you have been billed $240 of Medicare-approved amounts for covered services, 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 $240 of Medicare-approved amounts***	$0	$0	$240 (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 $240 of Medicare-approved amounts***	$0	$0	$240 (Part B deductible)
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 $240 of Medicare-approved amounts***	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Medigap 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 and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 (cont.)

Medicare (Part B) – medical services – per calendar year

***Once you have been billed $240 of Medicare-approved amounts for covered services, 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 $240 of Medicare-approved amounts***	$0	$240 (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 $240 of Medicare-approved amounts***	$0	$240 (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 $240 of Medicare-approved amounts***	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Other benefits—not covered by Medicare **Foreign travel—**Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
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

Medigap 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 and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 F (cont.)

Medicare (Part B) – medical services – per calendar year

***Once you have been billed $240 of Medicare-approved amounts for covered services, 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 $240 of Medicare-approved amounts***	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts***	$0	$240 (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 $240 of Medicare-approved amounts***	$0	$240 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Other benefits—not covered by Medicare **Foreign travel—**Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
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

Medigap Plan G

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 and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 G (cont.)

Medicare (Part B) – medical services – per calendar year

***Once you have been billed $240 of Medicare-approved amounts for covered services, 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 $240 of Medicare-approved amounts***	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts***	$0	$0	$240 (Part B deductible)
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 $240 of Medicare-approved amounts***	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Other benefits—not covered by Medicare			
Foreign travel—Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
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

Medigap Plan K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $7,060 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart. Once you reach the annual limit, the plan pays 100% of your Medicare copayment 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 between the amount charged by your provider and the amount paid by Medicare for the items or service.**

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 and board, general nursing and miscellaneous services and supplies**			
First 60 days	All but $1,632	$816 (50% of Part A deductible)	$816 (50% of Part A deductible)♦
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $102 a day (50% of Part A coinsurance)	Up to $102 a day (50% of Part A coinsurance) ♦
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 coinsurance for out-patient 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 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 (cont.)

Medicare (Part B) – medical services – per calendar year

****Once you have been billed $240 of Medicare-approved amounts for covered services, 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 $240 of Medicare-approved amounts****	$0	$0	$240 (Part B deductible)****◆
Preventive benefits for Medicare-covered services	Generally 80% 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 $7,060)*
Blood			
First 3 pints	$0	50%	50%◆
Next $240 of Medicare-approved amounts****	$0	$0	$240 (Part B deductible)****◆
Remainder of Medicare-approved amounts	80%	Generally 10%	Generally 10%◆
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 $240 of Medicare-approved amounts****	$0	$0	$240 (Part B deductible)◆
Remainder of Medicare-approved amounts	80%	10%	10% ◆

This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $7,060 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 between the amount charged by your provider and the amount paid by Medicare for the item or service.* Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*

Medigap Plan N

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 and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 N (cont.)

Medicare (Part B) – medical services – per calendar year

***Once you have been billed $240 of Medicare-approved amounts for covered services, 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 $240 of Medicare-approved amounts***	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copay of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copay of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B excess charges (above Medicare-approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts***	$0	$0	$240 (Part B deductible)
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 $240 of Medicare-approved amounts***	$0	$0	$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

Plan N (cont.)

Services	Medicare pays	Plan pays	You pay
Other benefits—not covered by Medicare **Foreign travel**—Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
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

Notes

Notes

For more information

Call us at **1-844-REGENCE** (1-844-734-3623) (TTY: 711).
8 a.m. to 5 p.m., Monday through Friday.
Or contact your local insurance producer or agent.

regence.com/medicare

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ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-319-0942** (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-319-0942 (TTY: 711).

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